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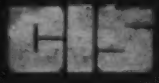

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ASSESSING THE AFFORDABILITY OF PRIVATE LONG-TERM CARE INSURANCE

HEARING

BEFORE

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION
ON
COMPREHENSIVE HEALTH CARE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

WASHINGTON, DC

NOVEMBER 8, 1989

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ASSESSING THE AFFORDABILITY OF PRIVATE LONG-TERM CARE INSURANCE

WEDNESDAY, NOVEMBER 8, 1989

THE PEPPER COMMISSION,
U.S. BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE,
Washington, DC.

The Commission met, pursuant to notice, at 9:30 a.m., in room B-338 of the Rayburn House Office Building, Hon. John D. Rockefeller IV (Chairman of the Commission), presiding.

Present: Senator John D. Rockefeller IV, Senator Dave Durenberger, Senator John Heinz, Senator David Pryor, Representative Bill Gradison, Representative Fortney Pete Stark, Representative Louis Stokes, and Commissioner James Balog, Commissioner John Cogan, and Commissioner James Davis.

Also present: Judith Feder, staff director; Edward F. Howard, general counsel; Steven C. Edelstein, Monica E. McFadden, Robert B. Friedland, Janis E. Guerney, Philip Shandler, Robyn I. Stone, Judith G. Waxman, and Joy Johnson Wilson, professional staff; S. Mitchell Weitzman, staff assistant; and Jackie Shields, intern.

OPENING OF MEETING BY JUDITH FEDER, STAFF DIRECTOR, THE PEPPER COMMISSION

Ms. FEDER. I am going to go ahead and start the public hearing. I'm sure the Chairman will be right back and we are pressed for time this morning.

I would like to apologize for the rush, but we only have the room for a limited time.

I would like to introduce our guests this morning whom we have invited to address the issue of assessing the affordability of private long-term care insurance.

Our first speaker will be Joshua Wiener, a senior fellow at the Brookings Institution. Then we will hear from Bruce Jacobs, director of the Public Policy Analysis Program at the University of Rochester and, finally, we will hear from Stanley Wallack, president, LifePlans, Inc., and director of the Bigel Institute, Brandeis University.

Before Mr. Wiener begins, Mr. Gradison, do you have any comments you would like to make?

Representative GRADISON. No; but I would suggest that we let each of our panelists present their opening statement, and then open this up to discussion, rather than take time —if that is agreeable.

Mr. Wiener, you may proceed.

STATEMENT OF JOSHUA M. WIENER, SENIOR FELLOW, BROOKINGS INSTITUTION

Mr. WIENER. Thank you.

It is a pleasure to be here today. The question I would like to address today is what should the roles of the public and private sectors be in financing long-term care?

The choice of emphasis between public and private programs depends not just on differences in political ideology, but also on differences in what private initiatives are feasible and affordable and whom they would benefit. For example, if it were demonstrably possible to market private long-term care insurance that would protect a large majority of the elderly from hardship and reduce dependence on Medicaid, then many people would see little need for new kinds of Government intervention. Conversely, if private initiatives were not to prove so widespread or to play a major role in paying for nursing home and home care, then the case for an expanded public role would be stronger.

In brief, the research that we have done at the Brookings Institution has convinced us that both of the following statements are true. First, over the long haul, the next 30 years, there is a substantial potential for growth in private long-term care insurance. Private long-term care insurance should and can play a much larger role than it does now.

Second, over the next 30 years, it is unlikely that private insurance will play more than a modest role in paying for nursing home and home care. At the end of that 30-year period, a reasonably optimistic estimate would be that perhaps a third of the elderly might have private long-term care insurance that provides moderate financial protection.

As this Commission is well aware, the offering of any private insurance is a relatively recent development of the last 5 or 6 years. According to the Health Insurance Association of America, at the end of June 1989, there were only 830,000 long-term care insurance policies enforced, compared to 1.3 million policies ever sold, insuring, therefore, less than 3 percent of the elderly.

There have been barriers on both the supply side and the demand side. Let me just mention one on each side. Despite improvements in income, private long-term care insurance remains very expensive for most elderly. According to the Health Insurance Association of America, among policies introduced in 1988, with fewer coverage restrictions and better, although still imperfect inflation protection, policies cost an average of $920 per person, if purchased at age 65, and $3,010 for a person that purchases at age 79.

Thus, married, elderly couples must pay annual premiums of between $1,800 and $6,000 a year. A considerable amount of money by almost any measure.

On the supply side there have also been many barriers revolving around whether long-care is an insurable risk. But let me mention one barrier in particular, because this one is not going away anytime soon. Insurers have worried about the uncertainty associated

with the fact that long-term care is needed principally by the very elderly, those age 85 and older. The very long-term horizon between initial purchase and ultimate use of nursing home and home care involves great uncertainty and financial risk.

The policy bought at age 65 probably may not be used until age 85, 20 years into the future. Unforeseen changes in disability or mortality rates, utilization patterns, inflation and service costs, or rate of return on financial reserves can dramatically change a profitable policy into an unprofitable one.

Despite these supply and demand barriers, insurers are moving into the marketplace, but it is important to note that at this point insurers have much more experience selling policies than they do paying for claims. Thus, they still do not know whether this ultimately will be a profitable line of business.

To evaluate the potential role of long-term private care insurance we used the Brookings-ICF Long-Term Care Financing Model. Although no one knows for sure what the future will be like, our computer simulation model provides an order of magnitude estimate what the potential impact of private insurance might be over the next 30 years. We have projected the potential market for private insurance initiatives using relatively optimistic assumptions about the willingness of people to pay, and the willingness of insurers to offer it.

Our purpose was to try to get an upper bound estimate of what the world of private insurance might be. Our projections indicate substantial potential for growth for private long-term care insurance, but even under optimistic assumptions about who would participate, private long-term care insurance cannot be relied on to do the whole job.

The private sector approaches are unlikely to be affordable by a substantial majority of elderly, to finance more than a modest proportion of total nursing home and home care expenditures, or to have more than a modest impact on Medicaid expenditures.

For example, we estimate that by 2018, private long-term care insurance sold to the elderly might be purchased by between 25 and 54 percent of the elderly, and may account for 17 percent of total nursing home expenditures, and may reduce Medicaid expenditures by 1 to 16 percent, compared to what they would have been without private insurance.

Private insurance initially sold to people under age 65 would be more affordable, but it would still account for only about 17 percent of nursing home expenditures in 2018.

What accounts for this relatively modest impact?

There are basically two reasons: First, even with increases in income by the elderly over time, these policies are simply too expensive for most elderly, especially those who otherwise end up on Medicaid.

Second, although private long-term care insurance policies are rapidly evolving and improving, policies are limited in the amount of financial protection that they offer. Reimbursement levels usually do not increase with inflation, or if they do, benefits do not increase sufficiently to provide full inflation protection.

This can be a serious problem because a payment level that is adequate today will not be adequate in the future. An indemnity

policy with a $50 per day nursing home benefit purchased at age 65, when it is relatively affordable, will need to pay over $150 per day age 85, to have comparable purchasing power.

Now, there is no inherent reason why insurers couldn't eliminate these restrictions and provide better financial protection. The problem is that coverage and affordability are basically tradeoffs. That is, coverage improvement elected to make products more expensive, thus reducing affordability.

For example, fully indexing the indemnity level to inflation would probably increase premium payments for the elderly by about 30 to 40 percent.

To conclude I would like to make four points:

First, all projections into the future are estimates of what might happen if certain assumptions are met. The hard reality of 1989, is that private long-term care insurance plays an extraordinarily small role in paying for nursing home and home care. Thus, the burden of proof is on private long-term care insurance advocates as to why this will change radically in the future.

Second, a key question for this Commission is: How long are we willing to wait before there are major reforms in how the elderly pay for their nursing home and home care? Private insurance policies can be designed to fit any affordability criteria. As a result, asking how many people can afford private long-term care insurance is the wrong question. What really matters is whether and when long-term care insurance will actually pay for needed care for a substantial number of nursing home and home care patients.

From this perspective, it should be clear that reliance on private insurance is a very long-range strategy. There is little doubt that for many years to come, private insurance is unlikely to have much direct impact on how long-term care is financed. Even if all persons turning age 65 in 1989 bought insurance, this population will not become major long-term care users until after 2009.

Third, sensitivity analyses we have conducted using far more optimistic assumptions about future disability rates and the prices of nursing home and home care suggest that these assumptions can dramatically change the aggregate level of long-term care expenditures and substantially improve the affordability of private insurance. Even under the most optimistic scenario of low inflation and low disability, however, approximately two-fifths of the elderly would not have private insurance. Moreover, these extremely optimistic assumptions will not radically change the proportion of long-term care financed by private insurance, nor will private insurance have a much larger impact on Medicaid expenditures compared with less optimistic scenarios.

Fourth, and finally, both public and private efforts are needed to finance long-term care. Development of that market by the private sector with encouragement from the Government can and should make long-term care more affordable for a substantial fraction of the population. However, it is not realistic to envision the private sector covering the large majority of elderly or of supplanting public spending. During the early 1960's it was considered intolerable that only half of the elderly had some form of acute care insurance. Based on our work, private long-term care insurance will be lucky to reach that level of market penetration.

If this Commission wants to change how long-term care is financed in the near future, it will either need to recommend public policies which aggressively promote private insurance or change how Medicaid and Medicare cover nursing home and home care.

Thank you.

[The prepared statement of Mr. Wiener follows:]

ASSESSING THE POTENTIAL ROLE OF PRIVATE LONG-TERM CARE INSURANCE*

Joshua M. Wiener and Raymond J. Hanley
The Brookings Institution
1775 Massachusetts Avenue, N.W.
Washington, D.C. 20036
(202) 797-6266

* These opinions are those of the authors and should not be attributed to other staff members, officers or Trustees of the Brookings Institution.

Testimony presented at a hearing on private long-term care insurance, United States Bipartisan Commission on Comprehensive Health Care, The Pepper Commission, Washington, D.C., November 8, 1989.

What should be the roles of the public and private sectors in financing long-term care? Some believe that the primary responsibility for care of the elderly should fall on individuals and their families, and that the government should act only as a payer of last resort for those who are unable to provide for themselves. The opposite view is that the government should provide comprehensive long-term care for all older people, with little cost sharing and regardless of financial need. In this view, there is little or no role for the private sector. Between these polar views, many combinations of public and private responsibility are possible.

The choice of emphasis between public and private programs depends not just on differences in political ideology, but also on differences in what private initiatives are feasible and affordable and whom they would benefit. For example, if it were demonstrably possible to market private long-term care insurance that would protect a large majority of the elderly from hardship and reduce dependence on Medicaid, then many people would see little need for new kinds of government intervention. Conversely, if private initiatives were not to prove so widespread or to play a major role in paying for nursing home and home care, then the case for an expanded public role would be stronger.

In brief, the research that we have done at the Brookings Institution (partly summarized in our book with Alice Rivlin and Denise Spence, Caring for the Disabled Elderly: Who Will Pay?, Brookings Institution, 1988) has convinced us that both of the following statements are true: First, over the next thirty years, there is a

substantial potential for growth in private long-term care insurance. Private insurance can and should play a larger role than it does now. Second, over the next thirty years, it is unlikely that private insurance will play more than a modest role in paying for nursing home and home care. At the end of that time period, a reasonably optimistic estimate would be that perhaps a third of the elderly might have a private long-term care insurance policy that provides moderate financial protection.

Demand and Supply Barriers for Private Insurance

The offering of any organized private sector financing mechanism for long-term care is a recent development of the last five or six years. According to the Health Insurance Association of America (HIAA), as of the end of June 1989, there were only 830,000 private long-term care insurance policies in force (compared to 1.3 million policies ever sold), insuring less than 3 percent of the elderly. Development of private sector initiatives has been slow because of barriers on both the demand and the supply side.

On the demand side, there have been several impediments. Historically, the elderly have been disproportionately poor. This is less true now as the income of the elderly has increased substantially over the last twenty years. While the elderly still have the highest poverty and near-poverty rates of any adult group, most current evidence suggests that the elderly as a whole are roughly as well off as the rest of the population. Most estimates of the future income and

assets of the elderly project substantial further improvements over time.

Despite improvements in income, private long-term care insurance remains very expensive for most elderly. According to HIAA, among policies introduced in 1988 with fewer coverage restrictions and better (although still imperfect) inflation protection, policies cost an average of $920 per person if purchased at age 65 and $3,010 per person if purchased at age 79. Thus, married elderly couples must pay annual premiums of between $1,800 and $6,000 per year, a considerable amount of money by any measure.

Moreover, there has been a lack of awareness of the risk that people face of needing long-term care. Most research suggests that persons who live to age 65 face a 40 percent chance of spending some time in a nursing home before they die. Few people have been willing to plan for their significant risk of becoming seriously disabled and using expensive home care or nursing home care.

Finally, there has been extensive misinformation. Many people think that Medicare or their Medigap policies cover long-term care. They do not. The debate prior to the passage of the Medicare Catastrophic Coverage Act served to educate the public on this point.

On the supply side, there have also been several barriers revolving around whether long-term care is an insurable risk. Insurers have worried about "moral hazard," the increased use of services likely to occur with insurance. Since most long-term care is provided by family at no formal cost, the possible increase in use is large. This

is especially true for home care since only about 25 percent of the disabled elderly in the community receive paid home care.

In addition, they have worried about adverse selection. That is, that people who "know" they will use long-term care care services will disproportionately buy insurance, driving up use beyond expectations. This creates a vicious circle where premiums have to be raised, causing low risk people to drop their policies, forcing an additional increase in premiums.

They have also worried about the uncertainty associated with the fact that long-term care is needed principally by the very elderly, those age 85 and over. The very long time horizon between initial purchase and ultimate use of nursing home and home care involves great uncertainty and financial risk. A policy bought at age 65 probably will not be used until age 85, 20 years into the future. Unforeseen changes in disability or mortality rates, utilization patterns, inflation in service costs, or the rate of return on financial reserves can dramatically change a profitable policy into an unprofitable one.

Despite these demand and supply barriers, insurers are moving into the marketplace. Although policies are improving, many still have restrictions. Most insurers are still being extremely cautious about who they will sell policies to--rejecting 10-20 percent of all people who make application is not uncommon. In addition, they are not marketing products as aggressively as they might. It is important to note that, at this point in time, insurers have much more experience

selling policies than they do paying claims. Thus, they still do not know if this will be a profitable line of business.

Projections of the Role of Private Insurance

To evaluate the potential role of private long-term care insurance in the future, we used the Brookings-ICF Long-Term Care Financing Model. Although no one knows for sure what the future will be like, our computer simulation model provides an order of magnitude estimate of what the potential impact of private insurance might be over the next thirty years. For the simulations we will discuss today, we assumed that mortality rates would continue to decline, disability rates would remain constant, nursing home and home care use rates would remain constant, incomes and general inflation would continue to grow at moderate levels, and nursing home and home care inflation would be somewhat higher than general inflation. In general, these assumptions reflect those used by the Social Security Administration in their widely-used, mid-range Alternative II-B projections. Appendix I discusses our nursing home and home care inflation assumptions in detail.

We have projected the potential market for private insurance initiatives for the next three decades using quite optimistic assumptions about the willingness of people to pay and the willingness of insurers offer it. Our purpose was to determine the most that can reasonably be expected from the private sector with respect to

participation, proportion of long-term care expenses financed, and reduction in the use of Medicaid.

Some of our assumptions could be criticized as exaggerating the affordability and effectiveness private insurance in meeting the need for long-term care. Indeed, we would agree that some of our assumptions are not true predictors of future behavior. For example, in three of these simulations, we assume that 100 percent of persons who can buy policies for 5 percent of their income (and have $10,000 in nonhousing assets) buy insurance at ages 65 or 67, even though that would mean a very substantial increase in out-of-pocket costs for health care for most elderly.

Our projections indicate substantial potential for growth of private insurance for long-term care (see Figure 1 and Table 1 for detailed assumptions of the simulations and Table 2 for the results). A potential multibillion dollar market is almost entirely untapped. People purchasing these products will have better financial protection than they have now.

Even under our optimistic assumptions about who would participate, however, private sector financing cannot be relied on to do the whole job. Private sector approaches are unlikely to be affordable by a substantial majority of elderly, to finance more than a modest proportion of total nursing home and home care expenditures or to have more than a modest impact on Medicaid expenditures. For example, we estimate that by 2018, private long-term care insurance sold to the elderly might be purchased by 25-54 percent of the elderly, may account

for 7-17 percent of total nursing home expenditures and may reduce Medicaid expenditures by 1-16 percent compared to what would have been spent without private insurance. Private insurance initially sold to people under age 65 would be more affordable, but would still account for only about 17 percent of nursing home expenditures in 2018.

Private sector options have a relatively modest impact for two reasons. First, they are too expensive for most elderly, especially those people who would otherwise end up on Medicaid. Since total long-term care expenditures per capita age 65 and over exceed $1,300 a year, this is hardly surprising. Total (public and private) long-term care costs roughly equal Medicare Part B expenditures and exceed three-fourths of Medicare Part A expenditures. Thus, costs never become trivial even when spread over the whole elderly population.

Second, although private long-term care insurance policies are rapidly evolving and improving, policies now available are limited in the amount of financial protection that they offer. For example, policies often have pre-existing condition exclusions, age restrictions on who may purchase policies, and cover relatively little home care. Reimbursement levels usually do not increase with inflation, or if they do, benefits do not increase sufficiently to provide full protection. This can be a serious problems because a payment level that is adequate today will not be adequate in the future. An indemnity policy with a $50 per day nursing home benefit purchased at age 65 when its relatively affordable will needs to pay over $150 per day at age 85 to have comparable purchasing power.

There is no inherent reason why insurers could not eliminate these restrictions and provide better financial protection. The problem is that improved coverage and affordability are tradeoffs within the elderly population. That is, coverage improvements are likely to make products more expensive, thus reducing affordability. For example, fully indexing the indemnity level to inflation would probably increase premiums for nonindexed policies for the elderly by about 30-40 percent.

Group Insurance

One potential way out of this tradeoff is through group insurance geared to the nonelderly, working population. Unlike most acute health care insurance, 97 percent of long-term care insurance is sold on an individual rather than group basis. Because administrative and marketing costs are much lower for employer-sponsored group products, a purchaser can obtain more benefits for the dollar. In addition, since group policies are generally sold to the nonelderly, there is more time for reserves to build up, thus lowering premiums and improving affordability. Selling to a low-risk group of nonelderly also reduces adverse selection.

The employer-based group long-term care market is very new and untested. According to HIAA, only 11 of the 109 insurance companies that sell products in 1989 offer an employer-sponsored group plan. As of 1989, only about 39,000 employer-sponsored policies have been sold. In fact, these policies are better characterized as individual policies sold in a group setting than as "real" group policies. While a

promising development that should be encouraged, employer-based insurance is unlikely to have any impact for years to come.

The extremely low market penetration of employer-sponsored group plans reflects several factors. For insurers, the very long-time horizon between initial purchase and use of nursing home and home care that goes with selling to the nonelderly involves even more uncertainty and risk than selling to the elderly. A policy bought at age 40 may not be used until age 85, 45 years into the future. The uncertainties, which were already large, are compounded greatly.

Another barrier to the growth of the employer-sponsored long-term care insurance has been low consumer demand. Lack of awareness of the need for this type of insurance has been a recurrent theme in market research. As a result, few employees and unions have bargained for long-term care insurance. In those handful of companies that have offered active employees insurance, only a small percentage of employees have purchased policies.

Finally, while employers' interest in offering long-term care insurance is growing, their interest in helping to pay for the insurance is not. In virtually all sales of employer-sponsored long-term care insurance, the employee pays <u>all</u> of the costs. Employers see offering long-term care benefits as financially risky and sure to grow as the baby boom generation ages. Moreover, employers already face an unfunded liability for retiree health benefits that is commonly estimated to be between $200 and $300 billion. Thus, employers are not looking for another elderly benefit to which they will contribute.

Conclusion

To conclude, we would like to make four points:

First, all projections into the future, including our own, are estimates of what might happen if certain assumptions are met. The hard reality of 1989 is that private long-term care insurance plays an extraordinarily small role in paying for nursing home and home care. Thus, the burden of proof is on private long-term care insurance advocates as to why this will change radically in the future.

Second, a key question for this Commission is: How long are we willing to wait before there are major reforms in how the elderly pay for their nursing home and home care? Private insurance policies can be designed to fit any affordability criteria. As a result, asking how many people can afford private long-term care insurance is the wrong question. What really matters is whether and when long-term care insurance will actually pay for needed care for a substantial number of nursing home and home care patients.

From this perspective, it should be clear that reliance on private insurance is a very long-range strategy. There is little doubt that for many years to come, private insurance is unlikely to have much direct impact on how long-term care is financed. Even if all persons turning age 65 in 1989 bought insurance, this population will not become major long-term care users until about 2009. Reliance on employer-sponsored insurance, while a desirable development, would take even longer to effect who pays for nursing home and home care. The

active employee age 50 in 1989 will not begin to hit the stride of his or her long-term care use until 2024.

Third, sensitivity analyses we have conducted using far more optimistic assumptions about future disability rates and the prices of nursing home and home care suggest that these assumptions can dramatically change the aggregate level of long-term care expenditures and substantially improve the affordability of private insurance. Even under the most optimistic scenario of low inflation and low disability, however, approximately two-fifths of the elderly would not have private insurance. Moreover, these extremely optimistic assumptions will not radically change the proportion of long-term care financed by private insurance, nor will private insurance have a much larger impact on Medicaid expenditures compared with less optimistic scenarios.

Fourth, and finally, both public and private efforts are needed to finance long-term care. Development of that market by the private sector with encouragement from the government can and should make long-term care more affordable for a substantial fraction of the population. However, it is not realistic to envision the private sector covering the large majority of elderly or of supplanting public spending. During the early 1960s, it was considered intolerable that only half of the elderly had some form of acute care insurance. Based on our work, private long-term care insurance will be lucky to reach that level of market penetration. If this Commission wants to change how long-term care is financed in the near term, it will either need to recommend

public policies which aggressively promote private insurance or which change how Medicare and Medicaid cover nursing home and home care.

FIGURE 1
Summary of Private Long-Term Care Insurance Simulation Assumptions

ASSUMPTIONS	BIG BEN	LOW BEN	NEW POL 5%	NEW POL 3%	YOUNG INS
Nursing Home Payment Per Day	$50	$50, $40, $30	$50	$50	$50
Indexed Benefit	$2.50 for 10 years	$2.50, $2.00, $1.50 for 10 years	$2.50 until age 85	$2.50 until age 85	Fully indexed at 5.8%
Deductible	100 days	100 days	100 days	100 days	90 days
Length of Coverage	6 years	6 years	4 years	4 years	1 year to unlimited
Prior Hospitalization Required	Yes	Yes	No	No	No
Any Home Care Benefits	Yes	Yes	Yes	Yes	No
Premiums					
50 year old	N/A	N/A	$236	$236	See Table 1
60 year old	N/A	N/A	$413	$413	"
65 year old	$584	$584-$350	$583	$583	"
80 year old	$1,642	$1,642-$985	$1,676	$1,676	"
Indexed After Purchase	No	No	No	No	Yes
Purchase Assumptions					
Can Disabled Buy?	No	No	No	No	No
Premiums as % Income/Assets					
Age < 55	N/A	N/A	<1%/NA	<1%/NA	<1%/NA
Age 55-64	N/A	N/A	<3%/NA	<1%/NA	<1%/NA
Age 65+	<5%/$10K	<5%/$10K	<5%/$10K	<3%/$10K	<3%/$10K
Does One Person Buy If Couple Cannot Afford 2 Policies	No	No	Yes	Yes	No

TABLE 1

ANNUAL PREMIUM AT ISSUE FOR NURSING HOME COVERAGE OF $50 PER DAY STARTING AT AGE 65 WITH 90-DAY ELIMINATION PERIOD, 5.8 PERCENT ANNUAL INDEXING OF COVERAGE AND LIFETIME PREMIUMS AFTER ISSUE, AND WAIVER OF PREMIUM FOR NURSING HOME RESIDENTS OVER AGE 64

Year of Issue	Issue Age	Years of Coverage 1	2	4	6	No Limit
1986	30	$127	$228	$350	$412	$486
	40	156	280	431	507	599
	50	199	356	546	644	760
	60	294	525	806	950	1,123
	65	362	647	991	1,166	1,398
	70	468	843	1,294	1,519	1,785
	75	621	1,127	1,736	2,026	2,369
	80	824	1,517	2,341	2,713	3,135
2021	30	148	268	412	485	574
	40	182	328	505	595	704
	50	234	421	647	763	903
	60	338	609	937	1,105	1,309
	65	412	742	1,141	1,342	1,586
	70	526	952	1,467	1,723	2,033
	75	688	1,256	1,939	2,268	2,665
	80	909	1,680	2,600	3,021	3,516

NOTE: 1. Includes induced demand factors of 10, 11, 14, 16, and 23 percent for coverages of 1,2,4,6, and unlimited years of coverage, respectively.

2. Estimates assume no 3-day hospitalization requirement.

SOURCE: Office of the Actuary, Social Security Administration, July 25, 1986.

TABLE 2

Key Simulation Results for Private Insurance, 2018

Option	Percent of Elderly Participating	Percent of Total Nursing Home Expenditures Paid by Insurance*	Percent Change from Base Case Medicaid Nursing Home Expenditures*
BIG BEN	25	7	- 5
LOW BEN	45	12	- 1
NEW POL 5%	54	17	-15
NEW POL 3%	33	10	- 6
YOUNG INS	63	17	-12

SOURCE: Brookings-ICF Long-Term Care Financing Model.

* For NEW POL 5% and NEW POL 3%, the simulations include spousal impoverishment and Medicare SNF changes mandated by Medicare Catastrophic Coverage Act of 1988. BIG BEN, LOW BEN and YOUNG INS do not include these changes.

APPENDIX I

NURSING HOME AND HOME CARE INFLATION RATES

In the simulations presented in this testimony, we assume nursing home and home care payment rates increase by the Consumer Price Index (CPI) plus the Social Security Administrations Alternative II-B projections of real wage and fringe benefit growth. Nursing home and home care payment rates are assumed to increase 5.8 percent per year--4.0 percent for general inflation, 1.6 percent for real wage growth and .2 percent for fringe benefit growth. By contrast, in their mid-range projects of the long-run cost of the Medicare program, Health Care Financing Administration (HCFA) actuaries assume that the cost of skilled nursing facilities and home health agencies will increase 2.5 and 3.0 percent, respectively, faster than the CPI.

Implicit in our assumptions is that long-term care service costs have a heavy labor component and that, over the long run, wages and other benefits must increase at a rate roughly comparable with wages in the rest of the economy. If they do not, people will not work in this employment sector. Also implicit in our assumptions is that there will be little or no productivity improvements in providing nursing home and home care over the next thirty years.

Although information on the price of nursing home care and home care is not routinely collected, the Office of National Cost Estimates

in the Health Care Financing Administration has developed estimates of nursing home revenue per day. Between 1977 and 1988, nursing home revenue per day increased by an average compound rate of 9.6 percent per year, compared to an increase in the CPI of 6.3 percent per year--a difference of 3.3 percentage points. Over that time period, there were only two years in which the differential between the rate of increase in nursing home revenue per day and the CPI was less than 1.0 percentage point and seven years in which it exceeded 3.0 percentage points. Thus, by historical standards, our assumptions are very moderate.

In the future, three factors will continue to push wages higher for long-term care industry workers. First, the quality of care improvements envisioned by OBRA 1987 mandate better staff training. Second, current labor shortages currently appearing in the Northeast and elsewhere could portend a constraint on the labor supply that will bid up workers' pay. Third, as the older population grows, the demand for long-term care will also rise rapidly. Increasing demand will only further aggravate current labor shortages and serve to push up wage levels for the industry. Long-term care providers will need to increase wages at a rate roughly comparable to the rest of the economy in order to obtain workers and to promote the well being of the disabled elderly in their care.

Some observers argue that, over the long run, if labor costs continue to drive up nursing home and home care payment rates, there will be a substitution of capital for labor which moderate price

increases. This seems unlikely for two reasons. First, in our model, relative to the income of the average worker, nursing home and home care will not become more expensive because they are assumed to increase at the same rate. More fundamentally, however, long-term care is not an area that easily lends itself to "high tech" solutions. By definition, long-term care is the help needed to cope, and sometimes survive, when physical or mental disabilities impair the ability to perform the basic activities of everyday life, such as eating, bathing, dressing, toileting or moving about. It is a very "hands-on" activity. As such, it is hard to imagine what capital substitutes for labor will take place.

Chairman ROCKEFELLER. Bruce?

STATEMENT OF BRUCE JACOBS, DIRECTOR, PUBLIC POLICY ANALYSIS PROGRAM, UNIVERSITY OF ROCHESTER

Mr. JACOBS. Mr. Chairman, thank you for inviting me to speak to the Commission.

I have already had a chance to participate in an advisory meeting with your staff, and I am glad to be able to share my thoughts with you today.

Among the many questions that the Commission is addressing, one of the most fundamental is: "Can America's future elderly population protect themselves against the financial catastrophe of an extended nursing home stay?"

More specifically, can private long-term care insurance be afforded by the majority of Americans, as the baby boomers retire? And will such protection make a significant dent in public expenditures?

My purpose here today is to share some of my analyses of what we have learned in this regard, and how the debate around this issue has been framed.

As most of you know, the pioneering effort in the projection of affordability of long-term care has been the model developed by Joshua Wiener, at Brookings, and David Cannel [phonetic] at ICF Lewin Associates. The publication of Caring for the Disabled Elderly, which was coauthored by Alice Rivlin, was a major event, and many of its findings have already gotten wide circulation through congressional testimony.

Perhaps the most-often-quoted finding is as follows (this from congressional testimony of Joshua Wiener and Alice Rivlin): "We estimate that by 2016 to 2020, at best, private long-term care insurance aimed at those aged 65 and older may be affordable by 26 to 45 percent of the elderly, may account for 7 to 12 percent of total nursing home expenditures, and may reduce Medicaid expenditures by 2 to 5 percent."

It was in part on this basis that the call for a public long-term care insurance program was issued. Again, to quote: "The rationale for public long-term care insurance is that the use of long-term care is a normal, insurable risk of growing old, but that the private insurance market is unable to provide adequate coverage at a price affordable by most of the elderly."

There are four major points about the research on this issue to date I would like to make, and add some additional thoughts as well.

Point No. 1, the published results of the Brookings-ICF Long-Term Care Simulation Model show that with some financing plans most of the future elderly could be privately insured with long-term care insurance products.

Moreover, the initial estimates of the percentage reduction in Medicaid costs that were encapsulated in the sentence I read were topped by a factor of 3 or 4 to 1 in other results published in the book. In short, the press coverage and the congressional testimony, as I have been able to see it, did not do justice to the richness of

results that were published by Wiener and Rivlin in their quite good book.

Point No. 2, the Brookings-ICF model shows that the size of the long-term care financing problem over the long run may be much less, or much more than a single estimate suggests. And that, correspondingly, private capacity to purchase long-term care insurance may be much more, or much less, than most who have not read the Brookings reports carefully believe to be the case.

As with all large-scale simulation models, certain assumptions made in the programming and projections can have critical impact in changing the conclusions of the simulation model.

I was just at a conference last week of public policy researchers, and we had a panel on simulation models (including Josh's colleague, Gary Burtless), and one of the points we all made was that a major responsibility for microsimulation researchers is to place heavy emphasis on the range of outcomes that can emerge with various plausible assumptions about such key variables in this case such as the rate at which disability will necessitate long-term care needs in the future population, and the rate at which long-term care inflation will rise relative to other inflation over time. They can make very big differences in the simulation output.

Point No. 3, it is premature to conclude that microsimulation models to this point have in any way exhausted the supply of private sector proposals for financing long-term care.

We are going to hear from Stanley Wallack today, who has been looking with his own simulation model at other plans. There are a wide variety of proposals. Virtually every month we read about an innovative idea, or a new kind of plan starts being marketed. We are in a period of a great change and we have a great deal to find out about the promise of these new private sector ventures.

One of the things, for example, I would like to know out of both of the simulation models is how much long-term care insurance could be purchased if the elderly, and perhaps people before they reach their retirement years, simply dipped into some of their savings, in order to pay long-term care insurance premiums. To my knowledge, the results of such simulation runs have not been published.

Point No. 4, and this, I think, is in some sense a summary point and most fundamentally important—there is as yet no consensus in the research community on future private capacity to finance long-term care insurance. We have been at a variety of conferences, in a variety of settings, with a fair amount of disagreement on this issue. I suspect you would have disagreement today among all three of us on this central question, which is so important to the workings of the panel.

Let me share with you some final thoughts. The first I think is an important one, because it relates to new data results that are in the process of being made available and how we might interpret them. Namely, we must distinguish between what people can afford in purchasing long-term care insurance and what they would choose to purchase as long-term care insurance.

The original argument calling for public long-term care insurance was based on the proposition that at best most elderly people

would not be able to afford buying long-term care insurance. They would not have the private capacity.

It is one thing to justify a program based on financial incapacity to buy long-term care insurance. It is another to base a program on unwillingness to buy long-term care insurance. I do not prejudge whether that would be justified in the latter case, but merely raise the point. Those are two very different justifications.

Second, I have been following rather closely how this debate has been played out in your setting, in the media, among gerontologists, and among policy researchers. One thing strikes me very clearly—it is not obvious what the problem is. That is not to say that there is not a problem, but there have been many different definitions of the problem, and perhaps, they would require different solutions or policy interventions.

Is it the size of total long-term care costs we can expect in 30 years? Is it the size of Medicaid costs, if we have no policy changes? Is it the affordability of long-term care insurance? Is it the number of people who actually become impoverished when they are faced with the onset of the need for long-term care? Or is it something else?

One of the things I hope the Commission does is clarify precisely what the public policy problem is in making its recommendations.

Finally, let me share a thought about specifying what is an adequate private long-term care insurance product. One of the things obvious to me in discussing this issue is that people have very, very different definitions of the kinds of protection they feel are adequate. Some would like a traditional catastrophic cost backup, perhaps with a requirement for them to spend several thousand dollars in a nursing home before the long-term care insurance benefits kick in. Others would like more close-in protection, perhaps after a month in a nursing home. Those are very different kinds of policies, which would have very different kinds of price structures.

I would not presuppose my ability to predict what the market will signal in terms of what consumers want on this. And I would encourage the Commission to consider, and my fellow researchers to consider, a wide variety of plans in reporting potential long-term care insurance affordability in the future.

Thank you very much.

[The prepared statement of Mr. Jacobs follows:]

Assessing the Affordability of Private Long-Term Care Insurance Some Cautionary Thoughts

Testimony of

Bruce Jacobs
Director
Public Policy Analysis Program
University of Rochester

before

United States Bipartisan Commission on Comprehensive Health Care

November 8, 1989

I Introduction and Major Conclusions

There has been a good deal of position taking on the various issues related to long-term care financing. Some hold that government takeover of a larger portion of the costs is both inevitable (because individuals will not privately be able to afford the looming financial burdens) and appropriate (as a natural component of the social insurance health program we have for the aged). Others argue that private sector developments will be able to provide protection against the catastrophic expenses of long-term care for most Americans. Unfortunately the supply of proposals, both public and private, is large relative to the knowledge base upon which persuasive argument must be built.

To be sure, research over the last decade has reduced the uncertainty within which the policy debate is carried out. Thus, for example, we now know that the economic status of the elderly population has improved markedly, and that the aged are no longer a disproportionately disadvantaged group (Jacobs, forthcoming). As well, the improbability of a long-term nursing stay is now seen by many theoretically as an insurable event (Rivlin and Wiener, 1988). However to stick with these examples, we do not know whether the future elderly could exhibit the level of demand to support a private long-term care insurance industry that will protect most against financial catastrophe.

The potential long run impact of a particular policy intervention (or the absence of one) in the area of long-term care is difficult to gauge without a model of individual and

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institutional behavior that takes into account both the developing trends that will circumscribe the economic possibilities and the relationships between the various actors. For that purpose, microsimulation may hold some real promise in deciding some disagreements about factual premises and at least clarifying others.

The Brookings/ICF microsimulation model has appropriately received a great deal of attention in the policy making community since it is the first significant effort to answer questions like this. As one who has discussed a variety of the modeling issues with the researchers since the inception of this effort (and the research preceding it at ICF) and as a member of the ASPE Technical Advisory Panel reviewing the revision of the model for the Department of Health and Human Services I am quite familiar with its inner workings. I have followed with great interest the publication and dissemination of the model's first results and of their interpretation by decision makers, the press, and interest groups. While I believe the Brookings/ICF team has made a real contribution to the debate on long-term care policy, it is very important for the work of the Commission to understand what the first results of the model actually were and to place their findings in a broader context of how microsimulation models should be used.

There are four major points I would like to make this morning:

1. The most widely disseminated finding of the model (i.e., that a majority of the elderly in the future could not be covered by private long-term care insurance), does not do

justice to the richness of the results reported in Caring for the Disabled Elderly (Rivlin and Wiener, 1988). Specifically, the model shows that with some financing plans most of the future elderly could be privately insured.

2. As with all large scale microsimulation models, the results of the Brookings/ICF model are highly sensitive to certain key assumptions (e.g., how disability rates change over time and what the relative rate of inflation in nursing home costs will be). The Brookings/ICF model shows that the size of the long-term care financing problem may be much less (or more) than a single estimate suggests and that, correspondingly, private capacity to purchase insurance may be more (or less) than most who have not read their book and reports carefully believe to be the case.

3. Virtually every month private long-term care financing options are being proposed or marketed. Whether they be new insurance products, pension-related premium coverage, innovative home equity conversion plans or others, there are a significant number of possible financing mechanisms that might be modeled using microsimulation. Indeed, there are a few obvious, and simple, approaches to private financing that have not yet been run through the model (or not yet been reported). These would include the partial use of cash assets to help pay insurance premiums for example. It is much too premature to conclude that the use of microsimulation has exhausted the supply of private financing options.

4. Other microsimulation modeling efforts that touch on the area of long-term care finance are now underway. The dissemination and discussion of their results will sharpen the debate about what the data tell us. Researchers on long-term care in their response to the Brookings/ICF model have clearly shown there to be some significant areas of disagreement regarding key assumptions and modeling strategy. There is as yet no consensus in the research community on future private capacity to finance long-term care insurance. The Brookings/ICF research effort has made a major contribution

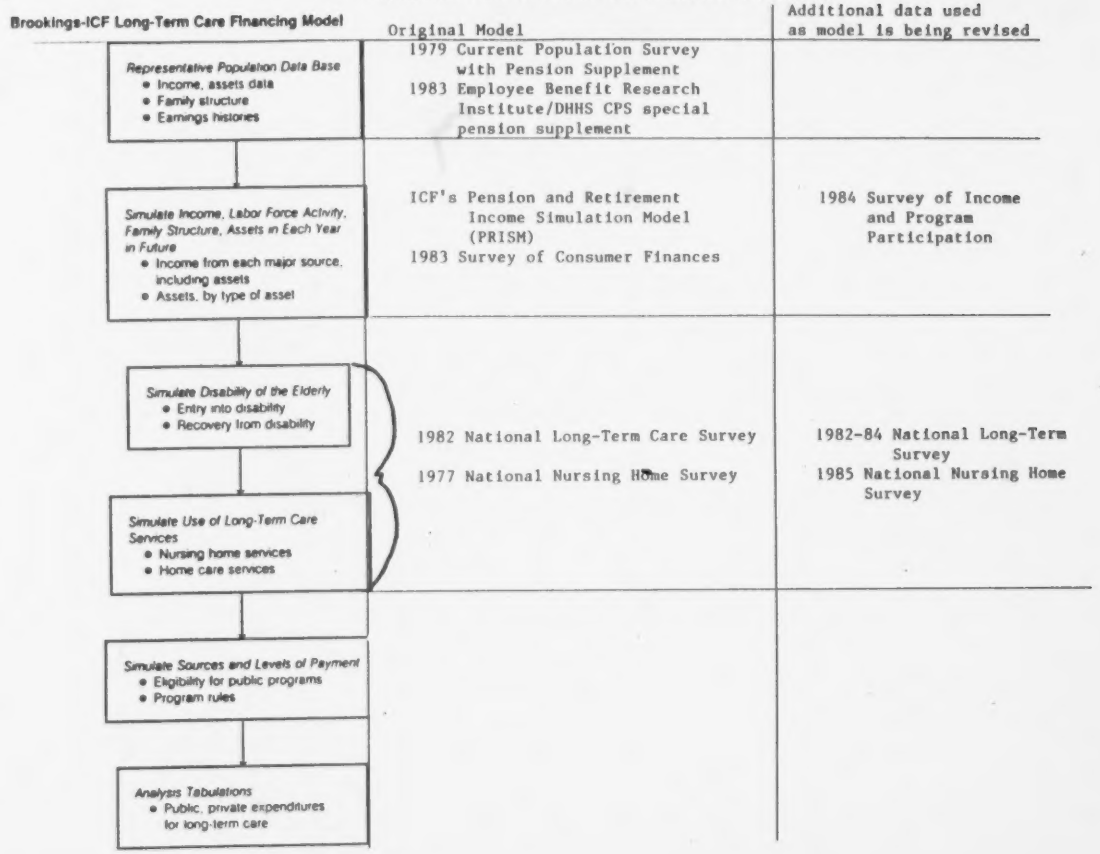
in beginning this dialogue. However, there will be much give and take to follow.

Modeling Long-Term Care Finance

The first major attempt to simulate possible future scenarios in the financing of long-term care is the development of a computer model by staff at the Brookings Institution, under the direction of Joshua Wiener, and at ICF, Inc. under the direction of David Kennell. Using Monte Carlo simulation techniques, the model projects over a 35 year period (1986-2020) the income and assets of the elderly population, their need for and use of long-term care, and how this care will be financed under various scenarios of public and private sector initiatives. The initial set of results was published in 1988 (Rivlin and Wiener). Figure I lists the extensive microdata sets that were used to estimate parameters in the original model and those that are currently being incorporated as the model is updated and revised.

The Brookings/ICF model has received a great deal of attention and has played an important role in the policy debate. This is true in no small part because it is a yeoman effort to grapple with an extremely complicated set of issues with the best data yet available. It is also true, however, because the issue has been pushed to the front burner among those who participate in policy making and because its first findings have been widely used to buttress a particular policy position -- the establishment of a major social insurance program to cover much of the cost of long-term care. How the model's results have been

FIGURE I
MICRODATA USED TO BUILD BROOKINGS/ICF SIMULATION


Brookings-ICF Long-Term Care Financing Model
Original Model
Additional data used as model is being revised
Representative Population Data Base
• Income, assets data
• Family structure
• Earnings histories
1979 Current Population Survey with Pension Supplement
1983 Employee Benefit Research Institute/DHHS CPS special pension supplement
Simulate Income, Labor Force Activity, Family Structure, Assets in Each Year in Future
• Income from each major source, including assets
• Assets, by type of asset
ICF's Pension and Retirement Income Simulation Model (PRISM)
1983 Survey of Consumer Finances
1984 Survey of Income and Program Participation
Simulate Disability of the Elderly
• Entry into disability
• Recovery from disability
1982 National Long-Term Care Survey
1977 National Nursing Home Survey
1982-84 National Long-Term Survey
1985 National Nursing Home Survey
Simulate Use of Long-Term Care Services
• Nursing home services
• Home care services
Simulate Sources and Levels of Payment
• Eligibility for public programs
• Program rules
Analysis Tabulations
• Public, private expenditures for long-term care

structured and communicated illuminates some of the difficulties of using simulation models and suggests some lessons for the future discussion of the issues surrounding this area of public policy.

In the context of these brief remarks it is impossible to do justice to the richness of analysis and discussion that has emerged from the Brookings/ICF model. I recommend to those interested the major publicly available documents (Kennell et. al., 1988; Rivlin and Wiener, 1988; Wiener and Rubin, 1989). For purposes of this discussion, I would like to focus on perhaps the major policy conclusion of the book, which called for a public long-term care insurance program. The logic, as developed from analysis of the model's simulation, is as follows:

> The rationale for public long-term care insurance is that the use of long-term care is a normal, insurable risk of growing old, but that the private insurance market is unable to provide adequate coverage at a price affordable by most of the elderly. (Rivlin and Wiener, 1988, p. 210).

The central output of the Brookings/ICF simulation model is an accounting (based on five year averaging) of how nursing home and other long-term care costs would be distributed among public and private sources over the period from 1986 to 2020 using various scenarios of private sector initiatives such as long-term care insurance, continuing care retirement communities, home equity conversion, and others. In order to estimate the potential impact of these plans, a base case is first estimated, assuming no new public or private sector plans. Thus, for example, the base case as estimated by the model indicates that

in the period from 2016 to 2020, yearly nursing home expenditures would be just over $98 billion (in 1987 dollars) thus tripling the costs of the 1986-1990 period. These monies would include $46 billion in Medicaid outlays, $1.6 billion from Medicare, $29 billion from patients' cash incomes and $22 billion from their assets. Of these components, Medicaid expenditures would go up the most -- 227 percent (Rivlin and Wiener, 1988, p. 42).

The introduction of a private sector financing option could change both the magnitude and the distribution of these costs. By simulating the degree to which these figures would be so affected into the future, some judgments can be made about viability of each of the options in helping to pay for long-term care. While prior research estimated the current ability of the elderly to pay for long-term care, and in some cases for insurance (Cohen et. al., 1987; ICF, Inc., 1984; Jacobs, 1984; Jacobs, 1986; Jacobs and Weissert, 1987; Moon, 1984; Moon and Smeeding, 1989), the Brookings/ICF results are the first serious efforts to project private financing capacity into the period in which the magnitude of total long-term care costs will inevitably increase substantially.

Affordability of Long-Term Care Insurance

To illustrate the sort of analysis done with the model, we can consider one of the insurance plans Brookings/ICF explored. Based on an actual product (then) recently put on the market, it would cover up to six years of nursing home care after a 100-day deductible and a prior hospitalization, providing a fixed

indemnity payment of $50 per day with a limited inflation adjustment after the first year. Among people aged 67 or more, those who could pay the premium with five percent or less of their income (and who had had at least $10,000 in assets) were assumed to purchase the plan.

The simulations showed that in the period 2016-2020 a market of but one quarter of the elderly population could possibly emerge. Only seven percent of nursing home costs could be covered by this private insurance plan and Medicaid costs would only be reduced by one percent (compared with the base case). A second insurance plan, with lower benefits and premiums, but a larger potential market, would cut Medicaid costs by five percent. Though several other plans for financing private long-term care insurance were reported in the book, the results from these two simulations received the greatest attention.

Exhibit I details a sequence of communications that emerged from the dissemination of these findings. Attention was clearly riveted on the notion that most of the elderly couldn't be privately insured and that such insurance would not appreciably reduce Medicaid outlays. However, the wording used by the New York Times and by AARP is not quite what was reported in the book. While the findings described in the testimony might leave the impression that these represented the outer limits of private sector capacity, results from some other simulations reported in the book said otherwise.

In fact the Brookings/ICF model was used to analyze a variety of approaches to buying long-term care insurance,

EXHIBIT I

...we estimate that by 2016-2020, at best, private long-term care insurance aimed at those aged 65 and older, may be affordable by 26-45 percent of the elderly, may account for 7-12 percent of total nursing home expenditures and may reduce Medicaid expenditures... by 2-5 percent.

- Alice Rivlin and Joshua Wiener
in Congressional testimony*

Ms. Rivlin and Mr. Weiner estimate that under the most optimistic assumptions private insurance would cover no more than 45 percent of the elderly and pay no more than 12 percent of nursing home costs.

- New York Times editorial**

"Private approaches are unlikely to be affordable to a majority of the elderly," say Alice Rivlin and Joshua Wiener... At best, they say, between 26 percent and 45 percent of older Americans will be able to afford long-term care insurance by the year 2020. However, such coverage would account for only 7 to 12 percent of total nursing home expenditures...

- AARP News Bulletin***

* Testimony of Alice Rivlin and Joshua Wiener before the U.S. Senate Budget Committee, March 17, 1988.

** "The Good News About Nursing Homes," New York Times, June 13, 1988

*** quoted in Steven Pressman, "The Long-Term Care Debate," AARP News Bulletin, May, 1988.

including initiating payments during the working years (hence allowing for lower yearly premiums), and converting home equity (where most of the elderly's assets are tied up) into income through reverse mortgages to pay premiums. In each case, the impact on public and private outlays was estimated. Table I summarizes some of these and other results. The lower portion of the table includes simulations done (after the book was completed) under contract with the Department of Health and Human Services, using a revised model that reflected the potential impact of the Medicare Catastrophic Coverage Act and updated insurance premiums (Kennell et. al., 1988). The ASPE report did not include simulations of the use of home equity to pay insurance premiums. However, the insurance simulations in the lower portion of the table allow for purchase before the retirement years are reached. In all of the simulations, the effect of insurance in reducing the money spent out-of-pocket from assets was greater than the effect reducing payments out-of-pocket from cash income.

There is significantly more variation in the potential impact of long-term care insurance as estimated by the Brookings/ICF model than has been reported in the popular press or is reflected in Congressional documents I have seen. Instead of a maximum coverage of 45 percent of the elderly population in 2016-2020, we see a figure of nearly 63 percent. The potential percentage of nursing home costs covered by insurance is nearly twice as high (22.8 vs. 11.7 percent) as previously reported by

TABLE I

BROOKINGS/ICF SIMULATIONS OF THE POTENTIAL IMPACT OF PRIVATE LONG-TERM CARE INSURANCE IN 2016-2020

	% of Elderly Covered by Insurance	% of Nursing Home Costs Covered by Insurance	% Reduction in Medicaid Outlays	% Reduction in Out-of-Pocket Outlays
Simulations reported in the book*				
"High benefit" insurance plan	25.4	7.0	1.2	12.0
"Low benefit" insurance plan	45.0	11.7	5.0	14.8
Insurance with purchase begun during working years	62.5	17.0	12.4	17.7
Insurance purchased with cash income and home equity converted into income (restricted)**	52.8	17.7	14.5	14.4
Insurance purchased with cash income and home equity converted into income (unrestricted)**	60.7	22.8	20.0	14.7
Simulations reported in the ASPE report***				
Insurance purchased on basis of "generous" affordability criteria****	54.4	16.8	15.1	13.8
Insurance purchased on basis of "restrictive" affordability criteria****	33.3	10.1	5.5	12.3

* Figures are derived from Alice Rivlin and Joshua Wiener, Caring for the Disabled Elderly (Washington D.C.: Brookings Institution, 1988).

** In the restricted case, the elderly homeowner had to have $10,000 in cash assets in order to convert home equity into income. In the unrestricted case, she did not.

*** Figures derived from David Kennell et. al., Financing of Long-Term Care, Final Report submitted to the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services, September 30, 1988.

**** The generous affordability criteria required that insurance premiums be below 1 percent of cash income for those under age 55, 3 percent for those ages 55-64 and 5 percent for those 65 or older. In the restrictive case, analogous percentages were 1, 1, and 3.

the press. Potential reductions in Medicaid outlays could by four times as as much (20 vs. 5 percent) as reported.

In part, the focus on a narrower set of figures reflects the necessity of boiling down a great amount of information to focus on key results -- something true of all large scale research efforts. However, my view is that three factors aggravated the situation in this case.

First, and perhaps most important for this discussion, is the complexity of this pioneering microsimulation research effort. The myriad of details in the research decisions that had to be made and the wide variety of simulations reported require a great deal of time to absorb. Though these are reported at great length in the book, few people participating in the policy debate have the incentive to wrestle with these matters given the costs involved. A second, related, point is that there was little, if anything, with which to compare the research results. The magnitude of effort involved in producing such a computer model makes entry into this research marketplace a difficult step. (Fortunately, some efforts are underway to remedy this gap.)

The third factor is not directly related to the Brookings/ICF simulation per se, but to the political context into which the results were released. In addition (and related) to the fact that 1988 was a presidential election year, a major lobbying campaign was underway to place a new public long-term care program on the political agenda. As might be expected, the use of this study's findings was long on drama and short on circumspection. Simply put, the resulting reportage did not do

justice to the extensive discussion and more careful wording in the Brookings book.

Sensitivity of the Model to Key Assumptions

One of the important points raised by Rivlin and Wiener, but not analyzed at great length, was the potential sensitivity of the model's results to some key assumptions that had to be made in specifying its parameters. When rates of change are compounded over thirty years or more, relatively small variations in assumptions can produce important differences in a model's output and, potentially, in the conclusions drawn from it.

Two of the central issues regarding the simulation of long-term care costs are the rate at which need for such care will rise and the rate of price increases over time. In the base case reported by Rivlin and Wiener, while life spans are extended over time as mortality rates decline, age-specific morbidity rates are assumed to remain constant. Hence, the total time an average person would need long-term care will increase over the thirty plus years of the simulation. Nursing home prices were assumed to increase 5.8 percent per year, they being set to equal the Social Security actuaries' middle (II-B) estimates of the long run increases in wages and other compensation in the entire work force. This is equivalent to a 1.8 percent real yearly increase in prices, which compounds to nearly 90 percent real over the period of the simulation.

Changes in these assumptions have major impact on the Brookings/ICF base case. Table II details the magnitude of these

TABLE II

SENSITIVITY OF TOTAL NURSING HOME COSTS
AND MEDICAID OUTLAYS FOR NURSING HOMES IN 2016-2020
TO ASSUMPTIONS ABOUT INFLATION AND DISABILITY RATES*

Total Nursing Home Costs ($1987 billions)

Nursing Home inflation rates	Disability Rates: low***	base case	high
low**		66.1 (-33%)****	
base case	74.0 (-25%)	98.1	120.85 (+23%)
high		145.4 (+48%)	

Total Medicaid Outlays for Nursing Homes

Nursing Home inflation rates	
low**	23.6 (-49%)
medium	46.2
high	84.1 (+82%)

* Figures derived from Rivlin and Wiener.

** Nursing home prices increase at 4.4, 5.8, and 7.2 percent yearly for low, base case, and high categories respectively (or .4, 1.8, and 3.2 percent real).

*** In the low disability rate scenario, disability rate declines match projected mortality rate declines. In the base case, mortality rates decline but disability rates remain the same over time. In the high disability rate scenario, disability rates increase at the same rate mortality rates decline.

**** Percentage difference from the base case.

shifts as reported in the book. The dimensions of the long-term care financing problem are obviously going to be fundamentally affected by long run variations in health and prices. Thus, for example, if disability rates decline over the long run, Rivlin and Wiener estimate that total nursing home costs could be reduced by a quarter. With somewhat lower inflation rates in nursing homes, total Medicaid outlays could be nearly one half (49 percent) lower than the model's projection. On the other hand, a very high inflation rate could mean total nursing home costs nearly one half (48 percent) higher than the most used public estimate. As Rivlin and Wiener point out, the evidence on changes in morbidity rates is mixed. One study summarizing previous research, and adding its own analysis, suggests that constant morbidity rates are a reasonable assumption (Porterba and Summers, 1987). However, this conclusion may be pessimistic (Newhouse, 1987). Any major breakthrough in research on Alzheimer's or Parkinson's disease may necessitate a shift in the specification of this important parameter.

Nursing home prices are perhaps even more difficult to predict. There are reasonable arguments to be made on both sides, though it seems unlikely that, over the long run, Medicaid reimbursements will be allowed to rise at an average annual rate of much over 2 percent real. Some argue that much of the cost of nursing homes is in low skilled labor, whose compensation has not risen as fast as that for the general work force. Moreover, large increases in input costs might provide an incentive for innovation to increase efficiency (especially if government and

private insurance reimbursement is held down). In point of fact, the initial Brookings/ICF model simulations used the lower (.4 percent real) inflation rate.

The case for a higher inflation rate is made perhaps most strongly by those in the Office of the Actuary who are responsible for projecting Medicare and Medicaid costs. They cite the role of increased intensity in the rise of nursing home reimbursement, which adds to the impact of rising input prices. However, one should note the institutional incentive in this case not to underestimate outlays. Moreover, if the nature of service is changing, which may be appropriate (Institute of Medicine, 1986), we should be cognizant of the fact that the simulated prices in the out years are for a substantially better level of service than is now supplied in nursing homes.

The Rivlin/Wiener book did not generally report what the impact of private sector initiatives would be in an environment with lower (or higher) rates of inflation or disability. However, some sensitivity analysis was done for ASPE, with a focus on the possible impact of insurance on nursing home financing. Table III details some of the results. We see that in the event of price or morbidity rates lower than assumed in the base case, public sector expenditures would account for a significantly lower portion of total costs (and, of course, would have risen much less dramatically). Most of the elderly could be insured, and their out-of-pocket outlays would be reduced as a result.

TABLE III
POTENTIAL IMPACT OF LOW DISABILITY AND NURSING HOME INFLATION RATES
ON NURSING HOME EXPENDITURES AND EFFECTS OF INSURANCE IN 2016-2020

	Revised Base Case	Low Nursing Home Inflation**	Low Inflation and Low Disability Rates***
Without Insurance			
Total nursing home costs ($1987 billions)	101.0 (100%)	67.5 (100%)	51.1 (100%)
Medicaid & Medicare Outlays	52.0 (51.5)	27.6 (40.1)	20.0 (39.1)
Out-of-pocket costs	49.0 (48.5)	39.9 (59.1)	31.1 (60.9)
With Insurance			
% of elderly covered by insurance****	54.4%	60.7	61.6
% of nursing home costs covered by insurance	16.8	13.7	13.3
% reduction in Medicaid outlays	15.1	7.1	6.7
% reduction in out-of-pocket outlays	13.8	17.4	16.8

* Figures are derived from Kennell et. al.

** Nursing home prices increase yearly .4 percent faster than the CPI.

*** Disability rates decline at the same rate as mortality rates.

**** Insurance purchased on basis of "generous" affordability criteria (See Table I).

It is impossible to know which of the scenarios will be most accurate. However, one clear message of this exercise is that policy conclusions emerging from the simulation may be quite sensitive to certain key assumptions. The lesson I would draw is that results should be presented with variations to illustrate the impact of central assumptions. The policy debate would thus be aided as focus could be directed at the major factual premises underlying the interpretation of results. In any projections of this length, there is bound to be room for disagreement and discussion (Light, 1985). I would encourage the Brookings/ICF team to present a variety of projections as they report results from their newly revised model.

One of the obvious facts about some of the behaviors modeled in the simulation of long-term care finance is that they will affect each other. In the real world they are endogenous. Since prices and supply of nursing homes (and home care) affect each other and, in turn, affect and are affected by government policies and private insurance, there is room for much more refinement in the simulation model. I do not know how the results might change. However, it is quite important to feed in some assumptions about, for example, the level of induced demand that might emerge in a more heavily insured population. Happily, efforts are underway to address this and other related issues.

When the story is eventually written, I believe the general assessment will be that the Brookings/ICF simulation model will have made a major contribution to the discussion of long-term care finance among policy researchers and government officials.

In part, this is because in interpreting its findings scholars and practitioners will be forced to specify the exact nature of the "problem." Is it the total level of public expenditures, the ability of private sector options to reduce them, the number of individuals who could protect themselves against a financial catastrophe, or something else? As well, the availability of the model to other researchers will allow for further sensitivity testing about assumptions and relationships between variables.

To be sure, as with other large scale simulation models there is likely to be continuing intellectual conflict (Kraemer et. al., 1987). However, we will be better informed as a result. Finally, I look forward to the development of competing models, which will increase the amount of information available to be considered in the public debates and may force all parties to confront more directly the underlying modeling issues.

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Chairman ROCKEFELLER. Mr. Wallack?

STATEMENT OF STANLEY S. WALLACK, PRESIDENT, LIFEPLANS, INC. AND DIRECTOR, BIGEL INSTITUTE, BRANDEIS UNIVERSITY

Mr. WALLACK. Thank you.

I am very happy to be here. The last time I had an opportunity to talk to Members of Congress on this issue when I was at the Congressional Budget Office, about 12 years ago. As we started to write papers on long-term care insurance there were very few people in Congress to talk to. So, I really appreciate this opportunity. I have a prepared testimony which I hope will go into the record. I would like to highlight some of the issues included in the testimony.

I have been working and looking at this issue for a number of years, ever since 1976 actually. And about 2 years ago, I had a sabbatical from Brandeis University and decided to set up a private company to work with private insurers in developing long-term care insurance plans. We have worked with a number of insurance companies over the last 2 years in developing products in the group market and in the individual market.

As Josh Wiener was saying, it is an emerging industry right now, with a lot of interest from the private sector.

So to place my comments in context, I have been both looking at this issue from the public and private sides.

The model that I have been asked to talk about is the LifePlans version of how one should look at the long-term care market. In particular, the model that I am going to be describing today is one that estimated at long-term care costs and utilization and tried to look at the potential of the private insurance market, and with this model asked what would Government policies do to affect the growth of private insurers.

My major emphasis today is on the demand for private insurance and its growth. But before I do that, I would like to take this opportunity to present the overall model and framework in which LifePlans is looking at the potential of the private insurance market. After I present the model and some of the results, I would like to raise a few points that fall out of the analysis.

First of all—and there are a lot of tables and graphs that you have—let me make three or four points on the model which I think are very important.

What the model is trying to do, and it is very different from other models that are circulating around Washington—is depict the interaction between public and private financing. I think this Commission and Congress certainly realizes now, after the repeal of the catastrophic bill, that as you legislate more on social welfare issues that you can no longer develop public program in a vacuum. There is a large insurance industry out there that provides some similar benefits.

If you are going to understand what the public policy change is going to do you need to understand both what the private market is doing currently and how it will react to public sector changes. These behaviors need to be integral in any model and the model

needs to be an interactive model. That is, in fact, what we have tried to do in our modeling.

The other thing that we've tried to do in our modeling, which is I think very crucial, is build the private market into the baseline of the model. Right now we think of most business services in the United States as belonging in the private market. Thus, I believe we should ask ourselves what can, in fact, private long-term care insurance do without further governmental programs.

This seems to be the appropriate place to start. Twelve years ago when I started doing analysis on solving the financing problem, there was no private market. There wasn't, as Josh Wiener has just stated. There were no insurance carriers interested. It made sense to talk about a part C of Medicare or a social insurance bill.

It seems now, as the private sector certainly has interest, that we need to start with a different framework. We need to put the private sector, first in fact, in the model, and ask the questions in a different way. And I have a flow diagram which describes the way the model works now. Please refer to figure 10.

We start off with that kind of system, what expenditures are, what the costs are for different individuals, and then build in the typical private insurance products that are being offered, and try to estimate their potential growth.

Having done that, we then ask the question what will the different proposals, such as the Mitchell bill or the Kennedy bill (see figure 2)—what will that do to the private market?

Clearly, some of the proposed bills replace what the private market is doing—paying for catastrophic benefits. If this happens, the model looks at what is going to be the reaction in the private market.

We are trying to look at a series of decisions, which starts from the private market, looks at public interventions and then sees what, in fact, the final results of public and private financing are.

The third point about the model which I think is very important is that our model is accessible to policymakers; it is a PC model. We have talked to some of the staff on the Pepper Commission about sharing it with them; we have had them to briefings that explore the model and its functioning. It is done on a PC for a lot of reasons. It first of all, makes it accessible to people. Anybody taking on major policy issues now in the private sector and public sector needs to have a sense of what the basic relationships are, and particularly how they work. Because there is a lot of uncertainty you need to ask "what if" questions. And what you really want to do is what the previous speaker said, get some sense about the sensitivity—what are your major assumptions, try to vary your major assumptions and see what the results are.

Because we have developed our model in a PC version, and we list the assumptions, you—in the Congress and us, analysts—can change, for example, or vary the assumptions of affordability. We can change the benefits or eligibility assumptions of the plan. And you can, in fact, play out, right on the computer screen what the impact of the changes are. It is a useful model, and at some point in the future, we hope to share it with the Commission.

Because we made the model accessible, and because we wanted to put it on a PC, we don't use individuals as the unit of analysis.

This is not an individual-based microsimulation model. The model is built around groups. We use 40 groups in our model based on age, sex, and income status.

The initial results and some of the results of the model are provided in tables 3, 4, and 5. What is important in the baseline model and what we use in estimating demand for insurance, is the distribution of expenditures. Because one of the things you want to ask yourself in looking at the potential of private insurances is whether people are exposed to a high level of risks, and if so, what is the size of that risk. And, finally, is that something they want to insure against?

So one of the most important results of our analysis is the distribution of use and cost. The distribution is provided in diagram form in figure 5. This becomes an input in our model when we look at insurance; because when you are asking about insurance and why people want to buy private insurance, you have to ask yourself what is the value of buying private insurance.

So in effect you ask yourself the following questions: What is the value or cost of private insurance versus what is the risk or cost of going without private insurance? Logic is taken from traditional insurance theory in which you should ask the following question: With or without insurance, what is the respective cost perceived by the individual.

We have done the theoretical and empirical analysis and looked at these distributions. As economists we know, and you, as policymakers need to know, that we don't know how people evaluate risk. It is very subjective, some people are very risk averse, others, in fact, will take all sorts of risks. They will throw the dice.

Insurance, however, exists because people are risk averse, in general. Our model basically builds in different assumptions of risk adversity and sees what the effect is on the purchase of insurance. The decision whether it is a good buy or a bad buy is depicted on an equation. (See figure 6.) What I call A is the cost without insurance and B is with insurance. And A has to be greater than B if people are to purchase insurance. That isn't the whole story.

We all know that even though people have—whether it is life insurance or disability insurance—different individual preferences. Some people insure and some people don't for the same risk.

So what we have done in our analysis is allowed the propensity to insure to vary. People can overinsure, or people can underinsure. I look at the Medi-Gap market, for example, there is an awful lot of overinsuring going on. As I look at the long-term care market, I see underinsurance going on. We want to get a sense of this and understand it, that is the attitude toward risk protection for long-term care.

When we do our analysis, we start off with this economic purchase model of insurance, and apply it to those that can afford insurance. My numbers on affordability aren't very different from Bruce's and Josh's. See table 9 and table 9–A, which show what we believe is the range of affordability for the current elderly by age group. Including income and bringing in assets, these are our estimates. People may put into our model different estimates on affordability.

I think our numbers actually are fairly conservative. We are working, as I said, with a number of private insurance companies and I am surprised with the number of people with below $15,000 in income that are buying private policies. And the average policy out there being sold is the elderly of around age 70 and the average premium is about $100 a month.

I think the issue—much like Bruce was saying—is not really an issue of affordability, it really is one of demand or the willingness, in fact, to insure.

When we run our model, we use it assuming about 42 percent of the elderly can, in fact, afford insurance at $100 a month. When we run it, assuming people are neutral with regards to insuring risk, that is, they are neutral with regards to demand for insurance. People are risk adverse, they are neutral, if they do not underinsure or overinsure.

We estimate that today about 10 to 20 percent—and the assumptions vary with that model—of elderly individuals are likely to purchase, or could purchase insurance.

Now, let me talk about those results, the 10 to 20 percent in the context of what the current market is. As Josh said, the current private long-term care market is a heck of a lot less than that 10 to 20 percent that could afford it. Today, about 4 percent of the elderly have purchased a long-term care policy. I think this indicates a very negative attitude toward this insurance, one that turns out to be much more important than benefit or price difference. There are some things that insurance companies can do, and we see them doing it—they are trying to provide lifetime benefits, they are trying to provide home care. Also they are trying to now separate the fact that this is not a Medi-Gap protection, this is really a long-term care policy.

The private sector—insurance companies—are trying to look for better products and design more affordable products. But doing so will not lead to the vast market potential. I don't think they can do it by themselves. In fact, the insurance industry has difficulty moving into a new marketplace singlehandedly. Traditionally they have used employers and employer subsidies to achieve acceptance in the marketplace. You can track the growth of health insurance in this country or you can track disability insurance in this country. They didn't grow until employers supported them.

People don't necessarily like insurance companies, I guess. Or the products could be too difficult to understand. They like or trust their employer, they like their Government more, they like their church group more, and they like their housing environment or neighbors more. Having to get sponsors for long-term care insurance, I believe, is very important.

A question we all have to ask then is, if we want to explore the potential of the private market what can we do to help the employer, in fact, sponsor long-term care insurance?

Because undoubtedly, if you talk about the next 40 years and 50 years, the huge growth in this private market is going to be through the employer.

But the problem that we are faced with now, is the elderly market. And they are the ones who are buying this insurance. And, once again it is here that the Government has to do something. I

do not believe, although I still see growth in the private market of 30, 40, 50 percent a year, which is very substantial, that the potential of the private market cannot evolve without Government action.

Now, that Government action need not be very expensive. It could be a lot of education, real education, real knowledge. People are still uncertain out there about what is going on.

It also could take the form of various public programs, social insurance programs, tax changes. And I think if the latter were to occur, the effects of such a Government program would be more than a price effect. It will bring about a change in attitudes. That is what happened after Medicare. The purchase of Medi-Gap insurance policies increased. What is very crucial for the Government to understand is that it creates the mind set out there, the attitude of individuals.

Therefore by spending relatively little money, if it changes the attitude, you can have a magnified effect on the private market.

Let me conclude with two things. One is I think we have developed a useful model for people to use. One in which you can vary many of the things I've talked about and see the result. And we want to share it. We want this accessible to all policymakers.

The second thing, and I am underlining what Bruce said—is the issue is not affordability, the issue is demand. And while the problem of demand is a problem now for the private sector, I can only ask whether it wouldn't be true of the public sector as well. What would happen if you introduced a public program for the elderly that wasn't subsidized? What would be the reaction of the elderly community? If, in fact, they don't have a demand for this product on the private side, why would they be very happy with a public program?

Thank you.

[The prepared statement of Mr. Wallack follows:]

ESTIMATING THE POTENTIAL MARKET FOR PRIVATE LONG-TERM CARE INSURANCE

TESTIMONY OF

STANLEY S. WALLACK
PRESIDENT AND CHIEF EXECUTIVE OFFICER
LIFEPLANS, INC.

TO

PEPPER COMMISSION
WASHINGTON, D.C.

NOVEMBER 8, 1989

I appreciate this opportunity to testify before the Pepper Commission and to discuss the LifePlans' model for estimating long-term care service utilization distribution of costs and the consequent demand for private insurance. LifePlans was established in 1987 when I took a sabbatical from Brandeis University. The goal of the company is to develop and implement comprehensive private long-term care insurance programs.

Over the past two years, LifePlans has assisted in the design and pricing of policies for a number of the country's major insurance companies. This modeling effort began in February 1989 and is being supported by HIAA and is being done with Professor Thomas McGuire and his colleagues in the Department of Economics at Boston University. We have been successful in developing an operational model over the last 8 months because it has been built upon our pricing experience.

The major purpose of the research effort I am discussing today is to provide a better understanding of the impact and interaction of public financing program on the use of long-term care services and demand for private long-term care insurance. Before I discuss how we modelled the private demand for insurance, I would like to begin by presenting an overview of our modeling approach. Also, after presenting our approach and the potential of private insurance, I would like to comment on the importance of public sector. While the annual growth of private long-term care insurance policies sold from 1986 to 1989 has averaged well over 50 percent, I am concerned whether this rate can continue without

some actions, which need not be expensive, being taken by the public-sector.

A. The LifePlans Model and Rationale

When the U.S. Congress first began to recognize the long-term care financing problem in the late 1970s, the options laid before them were alternatives on how to finance the services federally. The options included social insurance (such as Part C of Medicare), state revenue enhancements or categorical grants. At that time, I was the Director of the CBO office that provided the reports for the U.S. Congress.

There were no private insurance plans for custodial long-term care in the 1970s and the private sector showed no interest in entering the market. In fact, a strong rationale for public financing to solve this social problem was the failure in the private market. In the early 1980s, insurance was recognized as the preferred financing strategy when the distribution of long-term care costs were found to be very skewed. Private insurance policies were beginning to emerge at this time, but public policy makers considered them as an afterthought or a gap filler. Given the current activities of private insurers, this rationale no longer holds.

Currently, there are over 100 insurance companies offering policies, and the number could grow rapidly if the demand expands. More importantly, the activities of the private sector and its emergence require re-thinking the boundaries or the roles of the private and public sectors in solving this major social problem.

Furthermore, I believe that the decisions which the public sector makes should incorporate both the potential and limitations of the private sector. My thinking, which is reflected in the model, has changed over the years in that public policy must begin by now asking how extensive private insurance can become with no new governmental programs. Once this is determined, the appropriate question becomes what is the impact of additional government programs.

In order to evaluate the alternative public and private solutions and partnership to the perceived inadequacies in financing long-term care, there is a need to understand the relationships between a number of important variables that relate to service use, costs, and financing methods. Constructing quantitative models is a good way to do this. In reviewing the state-of-the-art in long-term care modeling, we found the ICF/Brookings simulation model to be the most comprehensive and detailed model currently available to answer a number of important policy questions. The ICF/Brookings model employs a sophisticated simulation technique to estimate long-term care services use for the next 60 years.

Simulation modeling represents one method of quantitative analysis. However, this model "locks in" specified relationships and as applied delimits the private sector role. I believe, and this view was reinforced by the recent debate on the Medicare Catastrophic Act, that the relationship between private purchase decisions and public programs must be integral to public policy

making on social programs for the elderly. That is, making public policies as if there was no private market or on the assumption that the existing private market does not respond, is not adequate.

The focus of the LifePlans model is on estimating service utilization and demand for private insurance in the context of a changing public policy environment. That is, the presence of insurance is posited to affect behavior and the choice or form of private insurance will itself be affected by public policy. This "behaviorally oriented" model that allows for interaction between public and private actions provides estimates about future service use, the demand for private insurance, and the impacts of public programs in a dynamic manner.

The approach we adopted is described in Figure 1. The modeling starts with estimating cost and utilization rates. The total costs of long-term care and the distribution by the level of expenditure are inputs into the demand for private insurance. The supply of insurance is depicted by typical premium and benefits. The model projects these costs, distinguishing between private insurance, public payment and out-of-pocket expenditures. This sequencing allows estimation of how extensive private long-term care insurance could be or is likely to become with no new governmental strategies. The model, having done this, then incorporates additional financing strategies, such as social insurance, tax subsidies and Medicaid enhancements, that the government could pursue. Since government policies result in a private sector response, the analysis re-estimates policies sold

and distribution of costs by payer. The flow of our model is presented in Figure 2.

In recognition of how little we know about important variables and because our intention was to make the model both accessible and useful for policy makers, the LifePlans' inter-active model is PC-based and designed to illustrate the sensitivity of key assumptions. That is, all the assumptions can be easily modified to do sensitivity analysis. Given our limited knowledge, policy makers may be best served by sensitivity analyses which bound the ranges of uncertainty. As new knowledge is gained, the model can be modified in a straight forward manner.

The importance of accessibility and need for sensitivity analyses led us to a PC-based model. Having limited capacity, we are using 40 groups in our analysis to date. The groups are male/female, 5 age groups (65-69, 70-74, 75-79, 80-84 and 85+), and 4 income categories (less than $10,000, $10-15,000, $15-29,999 and greater than $30,000. Figures 3-5 describe some of the results, lifetime costs, 1990 long-term care costs and the distribution of cost.

B. Incorporation of Private Demand for Private Insurance

In LifePlans' approach private insurance is built into the base model using the expected long-term care costs that have been estimated. The decision to purchase insurance is grounded in economic theory in which the decision to purchase is made by a knowledgeable consumer by comparing the costs, including "the costs of risk", without insurance (A) and with insurance (B). The cost

of risk is subjective. It is the amount an individual is willing to pay over and above the expected payout of a policy to purchase insurance. Costs with and without insurance are figured for an average person in a group using the distributions generated in the base model. The model is constructed on an individual level so that the behavior of individuals in a group may differ. That is, not all people in a group are assumed to act in a similar manner. Recognizing this and the limits of the theory, a random variable (Y) is incorporated recognizing individual differences.

For an individual, insurance is purchased when: $A > B + Y$

where A = cost of risk and out-of-pocket cost without insurance

B = cost of risk and expected out-of-pocket cost with insurance, plus insurance premiums, less benefits of extra services

Y = normal variable

If our knowledgeable consumer is also risk neutral, an actuarial fair policy (priced at expected costs) will not be sold since insurers have no ability to cover their administrative costs. However, because there is a subjective cost to risk and some individuals are risk adverse, some are willing to pay more than the actuarial value of the policy. Furthermore, under certain assumptions the subjective cost of risk can be shown to be the variance in income lost as a result of being exposed to long-term care expenses. Because we do not know the degree of risk aversion, this key parameter is modeled assuming different maximum loading charges that individuals would be willing to pay for full insurance.

When the cost without insurance (A) exceeds the costs with insurance (B), some people in a group will purchase. But, not all individuals in a group have similar preferences. Uncertainty or ignorance in costs and benefits are further reasons why the comparison between A and B does not lead to definite yes/no decision to buying insurance. The random variable "Y" is included in the insurance purchase model to account for these factors. The variable Y, the attitude toward insurance, represents the reluctance of individuals in a group to purchase insurance. This attitude is unrelated to the costs and benefits of insurance, but has a significant affect as shown in Figure 7.

This economic theory of insurance requires that individuals realize the risks they face and the costs of these services. The elderly appear to be knowledgeable on both these issues. There is still significant confusion, however, as to whether or not Medicare would pay these costs. Also, we do not know how different income groups are impacted by the presence of Medicaid. In the LifePlans model, we determine and vary the proportion of a group by income and assets that are in the market for long-term care insurance. The economic model weighing benefits and costs then determines how many will purchase insurance. This parameter, how many are in the market, should be varied to test its sensitivity.

We are using estimates of between 30 and 50 for the percent who can purchase insurance. Once data is available, we can begin to bound the parameters. Using the income and asset cut-offs for each of the four income groups in the model (see Figure 8),

LifePlans' model would assume that over 40 percent of the over 65 population could be in the market for long-term care. As the age falls below 65, we can expect the proportion that could be in the market to increase.

Affordability as defined in our models becomes a constraint and this constraint becomes less restrictive as the income of the group increases. Having selected these percentages and using the distribution of long-term care costs and private premiums, we then estimate the proportion buying private insurance. In our calculations to date, the proportion comes to between 10 and 20 percent of the elderly population. In any case, the proportion far exceeds the current level of insurance purchase. To operationalize this negative attitude in our model, we reduce the value of "Y". C. Achieving the Potential of the Private Market

Private insurance companies can take some actions to increase the proportion of those insuring by altering the relationship between A and B. The movement of some insurers to lifetime benefits has met with market success. The inclusion of home and community care benefits, which are preferred by many, can be expected to expand the private market as well. Finally, the movement towards a "disability" notion has allowed insurers to distinguish their long-term care policy from Medicare or Medigap. While these improvements provide better value, or a lower loading charge, and will help maintain the high current growth of insurance policies, it is still reasonable to ask why so few individuals are purchasing private long-term care insurance plans. This is in

direct contrast to the Medigap market, where there appears to be overinsurance, including multiple policies and first dollar coverage.

I believe the most important obstacle for the private insurance industry is to build trust in the product. I suspect that private insurers cannot do this by themselves; individuals are more likely to look to their employer, religious group or fraternal organization for guidance. A review of the growth of health and disability insurance in this country indicates the importance of their being offered and subsidized through the employer. While the employer as a sponsor of long-term care insurance, either as a contributor or on an employee pay-all basis, offers the greatest potential in the long-run, it is the current elderly that are more likely to purchase a plan. Give or take a year or two, the average age of the new purchaser of an individual long-term care policy today is about 70 years old. Substantially changing the attitude of the elderly towards purchasing long-term care insurance plan will, I believe, require government action. For example, a major educational program could result in a major change in attitude at relatively little cost.

A Federal financing program could have a significant effect on the public's attitude. The Medicare program enhanced the private market for acute care health policies for those 65 years of age and over. In part, this was because health insurance premiums fell, but it may have changed the elderly's attitude towards the purchase of health insurance as well. A social

insurance or a tax subsidy for the purchase of private insurance could have a similar impact. That is, governmental actions would do two things. First, they could reduce the premium and thus widen the difference between A and B. More importantly, they would provide the necessary credibility to private long-term care insurance plans.

Concluding Comments

The model developed by LifePlans is useful in delineating the potential of the private market. While the model is based on private insurance purchase decisions that precede new government policies, it also can be used to judge how the private sector will react to government programs. The decision to purchase is based on costs and benefits subject to affordability. From our initial calculations, it appears that a major factor affecting the level of demand is not income per se but the elderly's attitude towards the purchase of long-term care insurance. Given this negative attitude, one has to wonder whether a federal long-term care insurance program that did not have substantial subsidies would be viewed positively by today's elderly.

FIGURE 1

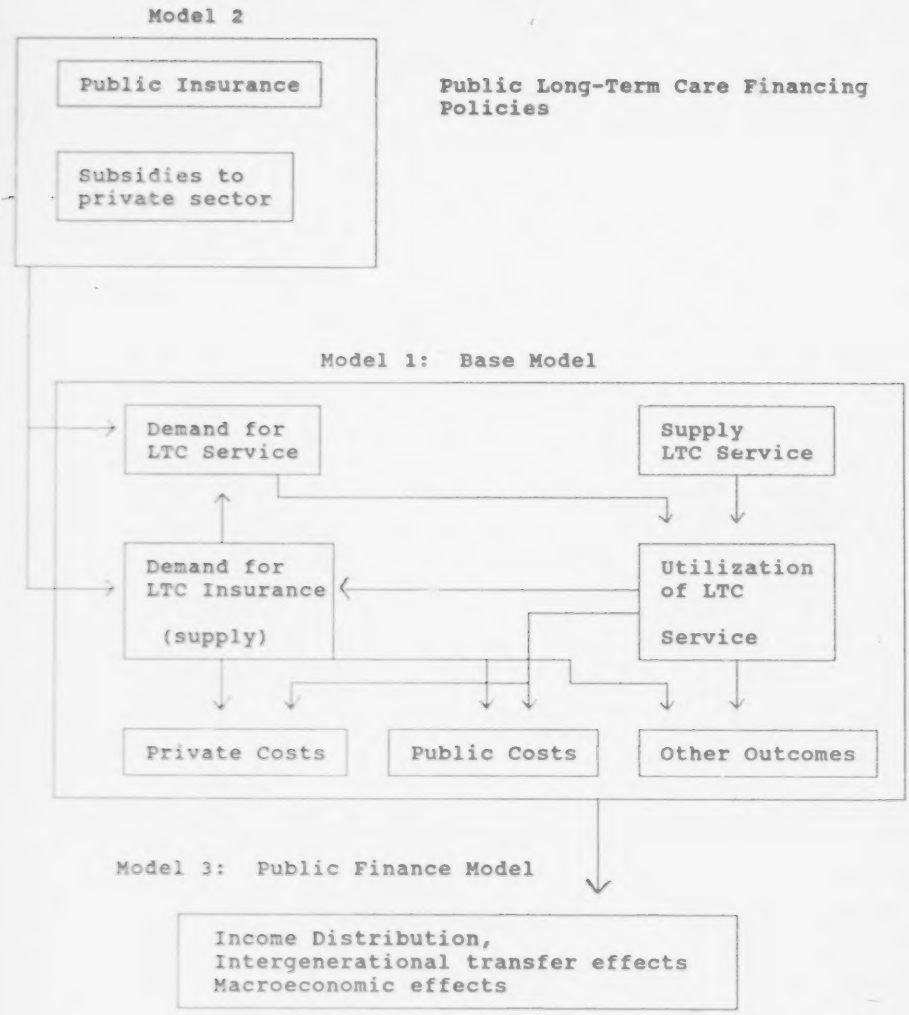
Model 2
Public Insurance
Subsidies to private sector
Public Long-Term Care Financing Policies
Model 1: Base Model
Demand for LTC Service
Supply LTC Service
Demand for LTC Insurance
(supply)
Utilization of LTC Service
Private Costs
Public Costs
Other Outcomes
Model 3: Public Finance Model
Income Distribution,
Intergenerational transfer effects
Macroeconomic effects

FIGURE 2

MODELLING FLOW

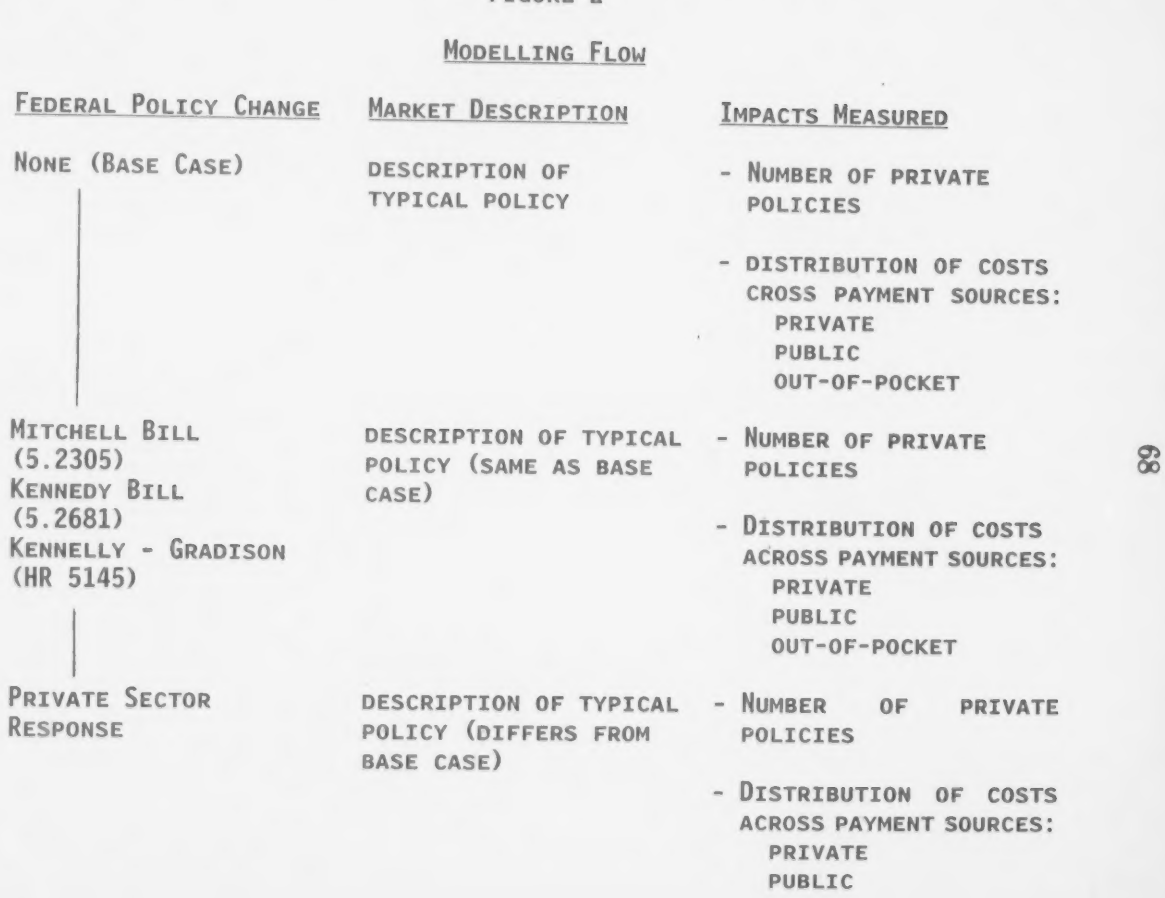

FIGURE 3

Lifetime Long-Term Care Costs

Expected Lifetime Costs

Age	Sex	LT* Prob NH Use	LT Prob HH Use	Avg LT NH Cost	Avg LT Cost HH Use	Total LT Cost
75-79	M	0.2825	0.1254	$22,823	$3,607	$26,430
75-79	F	0.5287	0.1662	$45,820	$5,539	$51,359

ASSUMPTIONS: Cost of Nursing Home Care is assumed at $70 per day, cost of home health care is assumed at $35 per day. 25% of the disabled use paid formal home care and on an average use 3.5 visits per week.

*LT = Lifetime

FIGURE 4

ESTIMATE OF LONG TERM CARE COST IN 1990

Popul.	Males (000)	Females (000)	Total (000)	Average Annual Total Cost	Average Annual HH Cost	Total Costs	Home Health Costs
65-69	4655	5596	10251	$ 323	$111	$3311073	$1137861
70-74	3516	4605	8121	$ 590	$143	4791390	1161303
75-79	2643	3691	6334	$1207	$213	7645138	1349142
80-84	1349	2478	3827	$2547	$293	9747369	1121311
85+	920	2347	3267	$7264	$752	23731488	2456784
TOTAL	13083	18717	31800			$49.2 (BILLIONS)	$7.2

ASSUMPTIONS: THE COST PER DAY OF NURSING HOME COST IS ASSUMED AT $70. COST PER DAY OF HOME CARE COST IS ASSUMED AT $35. IT IS ASSUMED THAT 25% OF THE DISABLED USE PAID FORMAL HOME CARE AND THAT ON AN AVERAGE THE NUMBER OF VISITS IS 3.5 PER WEEK.

FIGURE 5

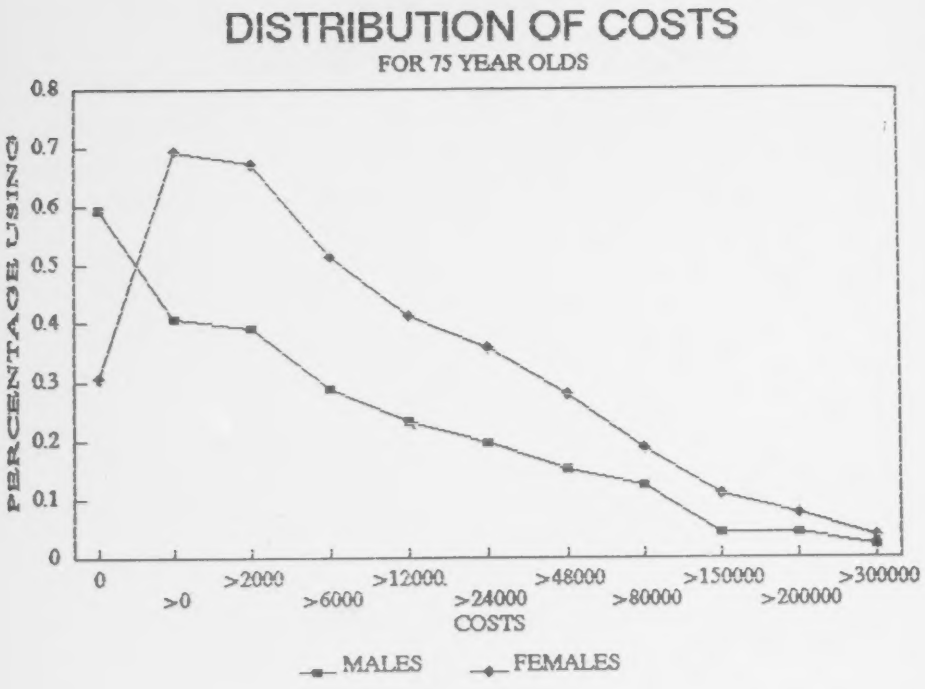
DISTRIBUTION OF COSTS
FOR 75 YEAR OLDS
PERCENTAGE USING
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
0
>0
>2000
>6000
>12000
>24000
>48000
>80000
>150000
>200000
>300000
COSTS
MALES
FEMALES

FIGURE 6

Model of Insurance Purchase

For an individual, insurance is purchased if:

(1) $A > B + Y$,

where A = cost of risk and expected OOP cost without insurance

B = cost of risk and expected OOP cost with insurance, plus insurance premium, less benefits of extra services

Y is a normal variable (μ, σ)

FIGURE 7

THE RELATIONSHIP BETWEEN INSURANCE PURCHASE AND NET BENEFITS

PERCENT PURCHASING

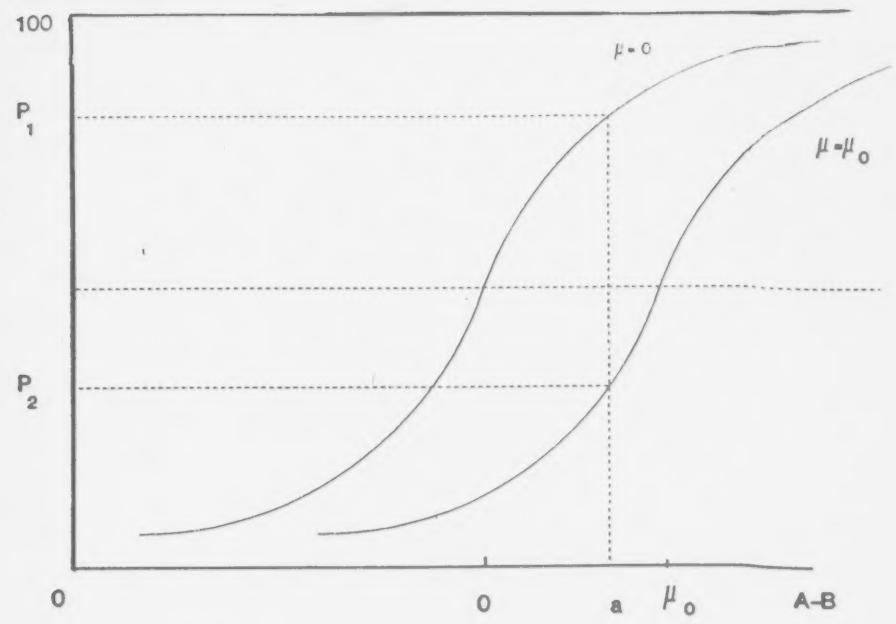

FIGURE 8

Income and Asset Criteria for Determining Who is Potentially in the Market for Long-Term Care Insurance

	IN THE MARKET ASSET LEVELS AGE		
Income Level	65-74	75-84	85+
<$10,000	Greater than $30K	Greater than $50K	Greater than $100K
$10,000-$14,999	Greater than $20K	Greater than $30K	Greater than 50K
$15,000-$30,000	Greater than $15K	Greater than $20K	Greater than $40K
>$30,000	Greater than $15K	Greater than $20K	Greater than $40K

FIGURE 9

Proportion Income-Asset Eligible for Purchase of Long-Term Care Insurance

Income & Asset Qualifying Group	Age Group Income-Asset Eligible 65 to 74	75 to 84	85+
<$10K (Appropriate Assets)	4%	3%	0%
$10K-$14,999 (Appropriate Assets)	7%	9%	6%
$15K-$30K (Appropriate Assets)	22%	18%	6%
>$30K & (Appropriate Assets)	21%	16%	6%
Weighted Total	54%	46%	18%

SOURCE: LifePlans estimates, SIPP, 1986 Aging America. Income of population over age 55, 1986.

FIGURE 9A

TOTAL ELIGIBLE MARKET

NOT QUALIFYING BASED ON

AGE	INCOME/ASSET	IN NH	DISABLED IN COMMUNITY	TOTAL COMBINED	TOTAL QUALIFING
65-74	46%	1%	7%	50%	50%
75-84	54%	6%	10%	52%	38%
85+	82%	21%	24%	92%	8%
WEIGHTED TOTAL	52%	5%	10%	58%	42%

Chairman ROCKEFELLER. OK.

Bill Gradison.

Representative GRADISON. Thank you, Mr. Chairman.

I believe that all three speakers have said that there are far more people who can afford to buy private long-term care insurance than will actually purchase it. My own view is that in the end we, as a Congress, are unlikely to come up with some kind of a first-dollar comprehensive long-term care plan.

If you put those things together that suggests that there is going to be some role for private savings, or private insurance in whatever we end up with. And that leads me to ask the question of all three of you, that Mr. Wallack addressed to some extent at the end, and that is how best can public policy simulate those who can afford to buy the care, but aren't doing so, to actually do it?

Mr. WIENER. Well, I think there are two parts to your question. One is what should the public sector do in terms of some programs, and then what should it do to encourage private insurance.

As you well know, I am in favor of expanding Medicare to cover more of the long-term care burden. Given the political environment, I have become increasingly convinced that the kind of plan proposed by Robert Ball is the direction that we need to be going in.

In terms of what we can do to stimulate private insurance, I agree with Stan that there is a need for general education, although I would say that the experience of Medicaid or Catastrophic is that we didn't do a terribly good job of educating people on that. So I am relatively pessimistic about the ability of Government to do that.

Clearly we can clean up a lot of things in the Tax Code. I testified just last week about a bill to provide private insurance to Government employees, and OMB was still saying that Treasury had tax concerns about how long-term care insurance benefits would be treated. We need to clean those up. I don't think that we ought to be providing tax credits and those kinds of tax incentives, because those tend to go to relatively upper income people, people who itemize, unless we are willing to go to a refundable tax credit, which we generally have not been willing to do.

But I don't agree with Stan or with Bruce that this is not an affordability problem. Affordability clearly depends on what your definition is, $1,000 per person per year is a good chunk of change and would require the elderly to substantially increase the amount that they currently spend on health care, which is already thought to be a very high percentage of their income.

In our simulations we had people buying insurance with 5 percent of their income, which would be roughly a 50-percent increase in their out-of-pocket costs for health care. And I think that is fairly substantial. And if we are going to count on people to spend—a married couple to spend $2,000 a year at age 65, let alone those age 75 and 80, I think we are whistling in the dark.

Mr. JACOBS. A couple of thoughts. One is that I would reiterate the assertion that education is quite important. And I wish I had the magic formula by which we could guarantee that all elderly people and the future elderly would realize the risk they face and what Medicare does not cover.

I would note in passing that there have been some attempts to do this, for example, in marketing the AARP-sponsored long-term care insurance product, which is not quite as successful as one would like.

Nevertheless, if we are going to expect the elderly and workers who look forward to their retirement to make rational decisions about private long-term care insurance, they've got to know what the risk is and have got to make those choices privately.

The second point I would make is that I would suspect quite strongly that the major efforts in this area and in formulations of new ways for financing that are not quite so painful as taking it out of current cash income will primarily be coming from the private sector. For example, a quite interesting idea of which I became aware several months ago was the notion of being able to enjoy some of your life insurance benefits on an early basis, if long-term care costs arose. And there are some plans that would allow you to take some of your death benefit on a fractional basis, year to year, as is needed. Of course, that reduces the death benefit, but nevertheless it is a kind of insurance that people have in large numbers.

I look forward to a good deal of innovation in the pension sector. We obviously are in a period where there are many people arguing about how pension assets should be invested and to what purposes they should be put. But there is an awful lot of private buying power there, financial commitments to individuals in their retirement years, and that is something that might be lubricated by public sector activity. But I think we are going to have to see how that plays out.

Finally, a somewhat more detailed point—I would share a thought Josh had, which is that insofar as there is public sector subsidy (implicit or explicit) for insurance, I would hope it would be targeted best to those who would have most difficulty buying it. And perhaps some care should be taken that they not be subsidies to those who have the most assets to protect in the first place, and who might well have a private incentive to take care of that on their own basis.

Mr. WALLACK. I would make a number of points, many related to education, it is just so important. And it doesn't matter which way the Government decides to go, full social insurance or encouraging the private market, you still want to get a population out there that thinks there is value in protection and there is a reason why they are getting that protection.

You need to find a way to do it. One of my biggest disappointments with the private sector now is the price of the product and how much they have to pay for sales; how much they have to pay for distribution. They are educating; it is a very expensive process. I think the Government could do it and do it relatively inexpensively. And if I had a few hundred million dollars, that's where I would put it at this point. No matter which way you go in legislation in making people knowledgeable at all ages about the problem they are facing, the risk they are facing and that they need to start thinking about it now is the most important step.

I don't think the answer should be just one approach, I think there are multiple approaches the Government needs to consider. I

think the issues about—I mean, anybody considering a solution to this problem needs to take into account improving Medicaid. I think—and making Medicare clearer with regards to its rules, who is eligible, with regards to what. The whole issue about spend-down, we don't understand it—how many people are sheltering their assets. There needs to be some clarity out there. We need to say that Medicaid is there for people who can't afford private insurance, perhaps, and Medicaid is there to provide access, and make the rules clearer.

I do know that in some States there is less purchasing of private insurance than in other States. These States have a more generous Medicaid Program.

So I would definitely want to improve Medicaid.

One of the things I would do is I would also improve Medicare in many ways. One of the things that we did at Brandeis when I was there was a social HMO, which really said let's organize the acute care market, let's try to tie some long-term care and acute care together. And we found in our four demonstrations that we are not spending anymore money for the Federal Government in providing long-term care, in providing drugs—doing a whole host of things in a care-managed system.

Somehow or other, if the Government managed Medicare better, it would have a big effect on freeing up some dollars. People pay $100 a month for Medi-Gap policies, or $75 a month. Why can't we take all that money, which 70 percent of the people are buying, and turn it into long-term care insurance?

So I think improving Medicare could have some real effects on this as well.

With regards to the employer market, you've got to concentrate on it. You've got to figure out something to do in the employer market. Maybe you've got to do something with regards to letting individuals put away some money and get some tax breaks for that. You've got to start getting people to think about this issue when they are young, when the premiums are much lower. We are talking about—I don't know whether it is $20 a month, or whatever it is for a 40-year-old, but we are talking about relatively little cost, if people would only start to save when they are 40 or 50. You know, you can't do it at 80, and it gets hard at 75, but most people can insure at 50. We've got to find a way to encourage that.

And I would, because of the current problems right now for the current elderly, I would provide a tax credit. There are a lot of people out there who can afford insurance, I would try to target it and limit it to a population that should really buy it, because I think Medicaid should be better and people shouldn't put money into insurance when they are close to Medicaid. But I would think a targeted, small tax subsidy would be another effective program to consider as well.

So, I think there are a number of strategies that make sense, but I don't think they have to cost a lot of money.

Commissioner BALOG. Somebody said a little bit ago very succinctly that the elderly, the 65-, 70-, 75-, 80-year-old people, are income poor and asset rich. Have you given much thought to how we could have asset conversion programs to help fund this long-term care?

Mr. JACOBS. Well, if you look at the current elderly population, most older folks have the majority of their savings tied up in their homes. And as many of you know, in recent years there have been a variety of, first experimental and now I am happy to say ongoing, private sector business efforts to let elderly homeowners convert some of the equity in their homes into an income stream, without having to sell their homes, or move.

It turns out that borrowing against the equity in their homes has a fairly large potential in the sense that the elderly who are best able to take out reverse mortgages are the ones who have the fewest years ahead of them, and they tend to be widowed and in advanced old age. These people are the most likely to be stuck with long-term care needs.

Correct me, if I am wrong, Josh—one of the results reported in the book Josh did with Alice is that, in terms of the elderly population itself buying long-term care insurance (as opposed to people starting to pay when they are younger), the conversion of home equity, to help pay insurance premiums would have maximized the coverage of the elderly population.

One of the things I would be quite interested to see would be some combination of people starting to pay during their working years for private insurance with lower premiums and then, if their cash income limitations in their older years had presented difficulty in paying the premiums, letting them borrow a little bit of their home equity to finish it off in their old age. There probably is a fair amount of potential there.

Again, one must distinguish between the economic capacity to do this and the desire or willingness to do it. How big the reverse mortgage or home equity conversion market is going to be I think is a very open question. There have been a few thousand loans written, and there are four or five private concerns doing serious business in about 15 States now. We will just have to see how far that goes.

But the assets are there, and will be there in greater numbers in the future, and in larger amounts. And I think that asset management is one of the important aspects of the whole long-term care business. We will probably see a lot more creative thought in the future than we have had even until now.

Commissioner BALOG. Just one followup. You touched on insurance, the conversion of cash value insurance as another conversion, how significant is that? What could you do with that, if you allow that to be a tax-free shift from a cash value life policy to a long-term care policy without a tax?

Mr. WIENER. I don't know what the pool is. Clearly, the problem with that kind of an approach is that it is the same as a nonindexed long-term care insurance policy. Most people have term insurance that is relatively large, but the universal life, whole life coverage that they have is relatively small. And so, I may have a $50,000 benefit today, but I am not going to use long-term care for 45 years, or longer. And the amount of money that I would get on a monthly basis 45 years from now is not going to be a very large proportion of the cost of my nursing home care.

Commissioner BALOG. I am talking about currently elderly.

Mr. WIENER. I don't know the size. Most people who have universal life, whole life kind of policies have relatively small policies.

Commissioner BALOG. We heard a number here a couple of weeks ago, $3 trillion, or $4 trillion cash value locked up in people over 65—a lot of money—I can't remember the exact number, but it was a lot of money.

Mr. WIENER. I don't know.

Mr. WALLACK. Insured life insurance?

Commissioner BALOG. A huge number, $3 or $4 trillion.

Mr. WIENER. Let me make a few comments on some of the points that Bruce made. First of all, I think it is really important to emphasize that the assets of the elderly is really overwhelmingly in that home. When you look at the assets of 85-year-old widows, the majority of them report less than $10,000 in nonhousing assets. So that is not a group that is going to have a lot of stocks and bonds. It is really in the home.

We did look at home equity conversion as an option, and I recommend our treatment there. It does improve the financial ability of the elderly to buy insurance, but it still doesn't result in anything approaching universal coverage.

Moreover, I think there is a very strong unwillingness on the part of the elderly, to use up their home equity to buy something as mundane as insurance. I mean, private long-term care insurance is important but, let's face it, insurance——

Commissioner BALOG. Because they want to leave it to their kids, you mean?

Mr. WIENER. They have this whole mythology built around the homestead, they want to leave it to the kids, they've paid the mortgage. They are very risk averse. They worry about what's going to happen; whether they're going to have money, whether they're going to be able to have their home.

The fact of the matter is that there have been more pages written on home equity conversion—many of them by Bruce—than there have been home equity conversions. [Laughter.] I think it is an idea that has attracted a lot of attention by academics, and I think—as a role, but it's just not going anywhere in the marketplace.

Mr. JACOBS. Josh, could I share with you what the State of Connecticut is doing——

Mr. WIENER. Let me just make one more point, then you can——

Chairman ROCKEFELLER. Let me interrupt you for purposes of clarification. Our Pepper Commission staff has looked at this life insurance amount, and it's between $3 and $5 trillion.

Ms. FEDER. Right, but there's a clarification which we could either provide you now or after. Those are liabilities. Those are the life insurance liabilities out there now, they are not the resources available to people to transfer to long-term care, and we have a staff memorandum that can clarify that issue.

Chairman ROCKEFELLER. That's for the purposes of the record.

Mr. WIENER. Just a final point, I think the future of home equity conversion for long-term care is in a kind of line-of-credit approach, not through a combination with insurance. That is because if you want to get people buying insurance at age 65 or 70, or even younger, the dollar value that you get through a monthly stream of

benefits through home equity conversion is very low. If you're waiting till age 85, you're likely to be disabled. The insurance company won't sell you the policy, and if they would it's going to be enormously expensive.

Chairman ROCKEFELLER. Jim Davis, at any point, is free to break into this because he was really before any of the three of you.

Commissioner DAVIS. This is a different question, right?

Chairman ROCKEFELLER. Yes; so, you go ahead.

Mr. WALLACK. I was just going to, again, put reality to this discussion a little bit by describing what's going on out there. Very often when you look at the elderly what we're seeing is elderly people turning to their kids very often, showing the policy to them and, in fact, children starting to support the policies of their parents as well. And there have been some surveys done about children's willingness to share some of the costs. So, if you start looking at affordability, we've got to consider families and not just the individual, and there are some kids who are interested in protecting the assets, too. So the market gets bigger, I think, as we look at the affordability issue and just keying in on the older person themselves we miss this.

Mr. JACOBS. If I may, just to continue Stan's point. Obviously, you don't want to manage your assets irrationally, you don't want to take a loan against your home equity assets when you're age 50—you might get just $25 a month because you've got 40 years ahead of you to live and, similarly, if you're 85 years old, you don't want initially to go into the private long-term care insurance market because the premiums, if the products will be available, will be extremely high.

The rational thing to do is to start with lower premiums, and then if you need extra cash, whether it be from assets you have in more liquid forms, or assets you have in the home, you can supplement your income to pay those premiums. There is not a singular method by which all insurance should be purchased.

I mentioned the State of Connecticut. Connecticut, in a very ambitious program begun a couple of years ago, is lending money to senior homeowners, and in the past year they added an option for long-term care needs where a lump sum up to $25,000 could be borrowed for the purchase of home care, or sometimes institutionalization. The program was so popular they ran out of money. They've had to refund it. It just was taken right up.

So, we really don't know what this is going to look like in the future. The assets are there, however, to supplement (but not necessarily be the sole source of elderly income for) the purchase of long-term care insurance or services directly.

Chairman ROCKEFELLER. Jim?

Commissioner DAVIS. Thank you, Mr. Chairman. Mr. Wiener, you mentioned that a policy bought at age 65 was not apt to be utilized until age 85. Was this simply an example of what could happen? Is that an average? Looking just at the elderly's portion of long-term care, do we have enough data to know what age, on average, the elderly find a need for use of this type of thing?

Mr. WIENER. I don't know that we have an average figure, but there is no doubt that if you look at, for example, the proportion of elderly in nursing homes between ages 65 and 74 it's about 1.5 per-

cent, between 75 and 84 it's about 5.5 percent, and at 85 and older it's 22 percent.

Commissioner DAVIS. This is constantly changing as elderly get healthier and this sort of thing?

Mr. WIENER. Well, it's not all that clear that the elderly are getting healthier. There's a lot of bitter debate in the research community about that, and I think there is no consensus on that whatsoever.

Commissioner DAVIS. They live longer, but they may not be——

Mr. WIENER. That's right. It may be that what our medicine is doing is pulling people back from the grave and leaving them in a more disabled state. Nursing home use rates have fallen somewhat over the last 10 years, but it's unclear whether that's a demand function or the fact that States have had moratoriums on construction and new beds.

Mr. WALLACK. I tried to give you some numbers, Mr. Davis, on figure 4 in the handout, which actually shows the dollars bracket by age, and our estimates at least for 1990, are roughly almost half for ages 85 and above, but it certainly showed that people in their high seventies—start to consume long-term care services in mid-seventies—is where you start to see the large increases. It's not linear, but the numbers there show the total expenses we estimate at LifePlans, and how it breaks down by age group. See figure 4 where it says total cost.

Commissioner DAVIS. I have a little followup. Mr. Wiener, you also said that indexing costs adds to the costs some 30 to 40 percent.

Mr. WIENER. For a policy bought at age 65, yes.

Commissioner DAVIS. On the face of it, it would appear that indexing would be a good thing for purchasers to do. Can I assume that indexing is a very inexact science today, and apt to be overpriced?

Mr. WIENER. Apt to be overpriced?

Commissioner DAVIS. Because of the uncertainty of how our costs are going to escalate in the future.

Mr. WIENER. What's available in current policies is basically—with few exceptions—a fixed increase, usually 5 percent of the initial indemnity value over some period of time. So, if you buy a $50-a-day policy for 10 or 15 years, it will go up at $2.50 a year which, by the time you get to that 15th year, is more like 1- or 2-percent inflation adjustment rather than a 5 percent.

Commissioner DAVIS. Is it a good thing for an elderly to index at 5 percent?

Mr. WIENER. I think it is absolutely critical that people buy a policy that has a good indexing feature, and it borders on fraud, in my view, to sell a policy to people age 50 or 45 that doesn't have an indexing policy.

Commissioner DAVIS. But the indexing may be excessive, it may be inadequate, it's all guesswork, isn't it?

Mr. WIENER. I think at this point in the market, there is nothing in the market that I would consider overindexed.

Mr. WALLACK. I'd like to comment on that. We have programs that have inflation and those that do not have inflation and we can observe what the elderly people want. They don't buy inflation pro-

tection. They don't want to pay the price for it. They really want as much coverage as they can get now, so the marketplace doesn't tell you they want it.

I think one of the issues we should ask ourselves is, whether or not there aren't better things they can get for a little higher premium. If you're indexing a premium, what you're basically doing now, since it's level funded, is you're paying up front today, for inflation out 30 and 40 years from now. I don't know any other products like that. I mean, people don't pay today's dollars for something that's going to happen 30 or 40 years from now, or 10 years from now.

So, it's very, and as Josh has said, expensive. Obviously, for younger people with low premiums it is more affordable. We see people in their seventies who are saying, I want as much protection now as I possibly can get. Finally, if I had to choose between indexing and what is called nonforfeiture, there's no doubt what I would choose. I would give people cash value and I think people are saying just that; they'd really rather have something that gives them value.

So, I think inflation protection is very expensive because of what it does to the premium, and I think there may be other ways of improving the product.

Chairman ROCKEFELLER. Let me interrupt. We've got to stop because others need the room. I will close with this thought, though. It's interesting to me that we've done a lot of talking about what people can afford and what will be available, very little talking about what kind of protection and benefits any of this would buy; nevertheless, that we can do.

I'm sorry I have to be so arbitrary, but they need the room and we've been here a while, and I thank all three of you very, very much.

[Whereupon, at 10:33 a.m., the hearing was adjourned.]

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